BOUDREAU FAMILY DENTAL
SMILE CARE FOR LIFE

JACQUES BOUDREAU, DMD
CYNTHIA YERED, DMD

MEDICAL HISTORY

Physician's Name: _____

Physician's office location: _____

Date of last physical: _____

Have you ever had an allergic reaction to the following?

Please check all that apply:

- ☐ Local anesthetics (eg Novocain)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates (sleeping pills)
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Other: _____

Women only, are you:

- ☐ Pregnant?
- ☐ Nursing?
- ☐ Taking birth control pills?

	yes	no
Are you currently under medical treatment?	☐	☐
Have you ever had any serious illnesses or operations? ...	☐	☐

If yes, please list: _____

Are you currently taking any medications?	☐	☐

If yes, please list: _____

_____

_____

Do you smoke?	☐	☐
Do you use alcohol?	☐	☐
Do you use recreational drugs?	☐	☐

Please check all that apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleed abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Fatigue Syndrome
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough - persistent or bloody
- ☐ Diabetes
- ☐ Emphysemia
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis - Type ____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other _____

DENTAL HISTORY

Former Dentist: _____

City, State: _____, _____

Date of Last Dental Visit: _____

Date of Last Dental X-Rays: _____

How Often Do You Brush? _____

How Often Do You Floss? _____

Do you have any dental issues you would like to discuss?

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Grinding Teeth
- ☐ Pain or Soreness
- ☐ Loose Tooth or Broken Fillings
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Cosmetic Treatment
- ☐ Sleep Apnea
- ☐ Sensitivity to Heat, Cold, or Pressure
- ☐ Other:

_____

_____

_____

_____