DR. CARL B. STEWART

291 West Renner Parkway, St. C
RICHARDSON, TEXAS 75080
972-238-9691

Name _____ **S.S.#** ___-___-___ **Date** _____

Date of Birth _____ **Age** _____ **Height** _____ **Weight** _____ **Marital Status** _____

Residence Address _____ **City** _____ **State** ____ **Zip** _____

Residence Tel. (___) _____ **Business Tel.** (___) _____

Driver's Lic. # _____ **E-Mail Address:** _____ **Fax #** _____

Employer _____ **Occupation** _____

Spouse's Name _____ **Employer** _____ **Bus. Tel.** (___) _____

Dental Ins. Co. _____ **Medical Ins. Co.** _____

Physician _____ **Address** _____ **Tel.** _____

Referred by _____ **Reason for this visit** _____

Date of last physical _____ **Date of last dental cleaning** _____

MEDICAL AND DENTAL HISTORY

PLEASE CHECK (✓) IF YES

HAVE YOU EVER HAD:
- Heart Trouble ❑
- Chest Pain ❑
- Shortness of breath ❑
- Swollen ankles ❑
- Heart Murmurs ❑
- Mitral Valve Prolapse ❑
- Heart bypass surgery ❑
- Rheumatic Fever ❑
- Artificial heart valve ❑
- High/Low blood pressure ❑
- Tuberculosis/Histoplasmosis ❑
- Lung Disease/Emphysema ❑
- Asthma ❑
- Hay fever ❑
- Hepatitis/Liver disease ❑
- Epilepsy/Seizure ❑
- Kidney or Bladder Disease ❑
- Diabetes ❑
- Cancer ❑
- Radiation/Chemo-therapy ❑
- Venereal disease ❑
- AIDS/HIV-Positive Test ❑
- Arthritis/Rheumatism ❑
- Psychiatric Treatment ❑
- Thyroid disorder ❑
- Artificail joints ❑
- Glaucoma ❑
- Complications from surgery ❑
- Prolonged bleeding after injury, tooth extraction, or surgery ❑
- A blood transfusion ❑
- Tendency to bruise easily ❑

AN UNFAVORABLE REACTION TO:
- Aspirin ❑
- Dental anesthetics ❑
- Penicillin or other antibiotics ❑
- Sulfa ❑
- Demerol ❑
- Barbiturates/Sedatives ❑
- Valium ❑
- Codeine ❑
- Other ❑

ARE YOU:
- In good health now ❑
- Under the care of a physician ❑
- Taking any medication **(list below*)** ❑
- Taking any of the following:
  - antibiotics ❑
  - anticoagulants (blood thinners) ❑
  - aspirin ❑
  - insulin ❑
  - cortisone ❑
  - blood pressure medication ❑
  - heart medication ❑

IF FEMALE, ARE YOU NOW:
- Pregnant ❑
- Taking birth control pills ❑
- Taking hormone medication ❑

HAVE YOUR EVER HAD:
- Periodontal treatment ❑
  when?_____
- Orthodontics ❑
- Any unpleasant dental experiences we should know about ❑

DO YOU:
- Smoke; how much?_____ ❑
- Now have discomfort or pain in your mouth ❑
- Grind or clench your teeth ❑
- Dislike the appearance of your teeth ❑
- Have bleeding gums ❑
- Have chronic bad breath ❑
- Have unpleasant taste in your mouth ❑
- Have shifting or separating teeth ❑
- Have loose teeth ❑
- Have teeth sensitive to cold, heat or sweets ❑
- Have swollen or tender gums ❑
- Ever have gum abscesses (boils) ❑

*** Please list all medications:** _____

Please add anything you feel important: _____

Medical Summary: _____

_____

Dentist's Signature _____ **Patient's Signature** _____