



Medical History

Patient Name _____ Date: _____

If you are completing this form for another person, what is your name and relationship to that person?

Name _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone _____

It is important that we know health problems you have and medications you are taking so that we may provide you the best possible dental care. Please answer the following questions.

___ Yes ___ No Are you now under the care of a physician?

If yes, please indicate the reason. _____

Name of physician _____ Phone: _____

___ Yes ___ No Have you ever been hospitalized or had a major operation? When? _____

___ Yes ___ No Do you have active tuberculosis?

___ Yes ___ No Do you have a cough that produces blood?

___ Yes ___ No Have you had an orthopedic joint replacement? When? _____

___ Yes ___ No Do you have any condition requiring premedication with antibiotics before treatment? _____

What condition? _____

WOMEN: Are you or could you be pregnant? ___ Yes ___ No ___ Don't know. Nursing? ___ Yes ___ No.

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes No?

- ___ ___ Abnormal bleeding
- ___ ___ AIDS or HIV infection
- ___ ___ Anemia
- ___ ___ Arthritis
- ___ ___ Rheumatoid arthritis
- ___ ___ Asthma
- ___ ___ Respiratory problems, **specify:** _____

___ ___ Cancer ___ ___ Severe headaches/migraines

___ ___ Chemotherapy or Radiation therapy

___ ___ Cardiovascular disease; **if yes, specify:** _____

___ ___ Heart Attack or heart trouble; **specify:** _____

___ ___ Blood pressure: High or Low **Circle One**

___ ___ Pacemaker

___ ___ Stroke

___ ___ Mitral valve prolapse or heart murmur

___ ___ Chest pain upon exertion

___ ___ Diabetes

___ ___ **Type I** (insulin dependent) or **Type II**

___ ___ Thyroid Problems: Hyper or Hypo **Circle One**

___ ___ Hemophilia

___ ___ Dry mouth

___ ___ Hepatitis, jaundice, or liver disease

___ ___ Recurrent infections, **if yes, specify:** _____

Yes No?

___ ___ Kidney problems

___ ___ Mental disorders; **if yes, specify:** _____

___ ___ Night sweats

___ ___ Neurological or psychological disorders;

specify: _____

___ ___ Persistent swollen glands in neck

___ ___ Sexually transmitted disease

___ ___ Swelling of any of the limbs

___ ___ G. E. reflux or persistent heartburn

___ ___ Eating disorder; **if yes, specify:** _____

___ ___ Gastrointestinal disease

___ ___ Fainting spells or seizures

___ ___ Venereal disease

___ ___ Systemic lupus erythematosus

___ ___ Rheumatic Fever

___ ___ Pain in the jaw joints TMJ/TMD

___ ___ Shingles

___ ___ Ulcers

___ ___ Blood Transfusion

___ ___ Epilepsy

___ ___ Scarlet fever

___ ___ Do you wear a removable full or partial denture?

Do you have any disease, condition, or problem not listed above that you think we should know about? _____

Please explain: _____

On a scale of one to ten, what is your level of dental anxiety? _____

What do you fear the most about dental treatment? _____

Approximately when was your last dental exam and cleaning? _____

Should we request x-rays from your former dentist? _____ Please provide his/her name and phone number:

Name: _____ Phone: _____

ARE YOU ALLERGIC, OR HAVE YOU EVER HAD A REACTION TO ANY OF THE FOLLOWING?

Yes No?

- ____ Local anesthetics: novocaine, xylocaine, etc.
- ____ Aspirin
- ____ Ibuprofen
- ____ Penicillin
- ____ Erythromycin
- ____ Any other antibiotics; **if yes, specify:** _____
- ____ Barbiturates, sedatives, or sleeping pills; **if yes, specify:** _____
- ____ Sulfa drugs
- ____ Codeine, or other narcotics; **if yes, specify:** _____
- ____ Latex
- ____ Iodine
- ____ Pollens, or do you have seasonal hay fever
- ____ Foods; **if yes, specify:** _____
- ____ Metals; **if yes, specify:** _____
- ____ Any other substance; **if yes, specify:** _____

If you answered yes to any allergy questions, please specify the type of reaction you had:

____ Yes ____ No Are you taking, or have you recently taken any prescription or non-prescription medicine(s)?

If yes, what medicine(s) are you taking, or have you recently taken? **List Them Below**

Please include the dosage and frequency of each.

Prescribed drugs: _____

Over the counter drugs: _____

____ Yes ____ No Are you taking any vitamins, natural or herbal preparations and/or food supplements?

If yes, please list: _____

____ Yes ____ No Are you taking, or have you recently taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or phen-fen (fenfluramine-phentermine combination)?

____ Yes ____ No Do you drink alcoholic beverages? If yes, how much did you drink within the last 24 hours? _____

____ Yes ____ No Are you alcohol or drug dependent? If yes, have you received treatment? ____ Yes ____ No

____ Yes ____ No Do you use drugs or other substances for recreational purposes? If yes, please list:

____ Yes ____ No Do you use tobacco (smoking, chewing, or snuff)? If yes, how interested are you in stopping?

_____ Very interested _____ Somewhat interested _____ Not interested

____ Yes ____ No Do your gums bleed when you brush or floss?

____ Yes ____ No Have you ever had periodontal (gum) treatment?

____ Yes ____ No Are your teeth sensitive to hot, cold, sweets or pressure?

____ Yes ____ No Have you ever had orthodontic treatment (braces)?

____ Yes ____ No Do you wear a removable dental appliance (night or athletic guard)?

____ Yes ____ No Have you had a serious/difficult problem associated with any previous dental treatment?

Please explain:

We would like to know the main purpose for your visit today, and please share with us your expectations:

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient/legal guardian _____ **Date** _____

Signature of Dentist _____ **Date** _____