

**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.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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? Yes No?**

\_\_ \_\_ \_\_ Abnormal bleeding \_\_ \_\_ \_\_ Kidney problems

\_\_ \_\_ \_\_ AIDS or HIV infection \_\_ \_\_ \_\_ Mental disorders**; if yes, specify:**

\_\_ \_\_ \_\_ Anemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ \_\_ Arthritis \_\_ \_\_ \_\_ Night sweats

\_\_ \_\_ \_\_ Rheumatoid arthritis \_\_ \_\_ \_\_ Neurological or psychological disorders;

\_\_ \_\_ \_\_ Asthma **specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_ \_\_ \_\_ Respiratory problems, **specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_ \_\_ \_\_ Persistent swollen glands in neck

\_\_ \_\_ \_\_ Cancer \_\_ \_\_ \_\_ Severe headaches/migraines

\_\_ \_\_ \_\_ Chemotherapy or Radiation therapy \_\_ \_\_ \_\_ Sexually transmitted disease

\_\_ \_\_ \_\_ Cardiovascular disease; **if yes, specify:** \_\_ \_\_ \_\_ Swelling of any of the limbs

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_ G. E. reflux or persistent heartburn

\_\_ \_\_ \_\_ Heart Attack or heart trouble; **specify:** \_\_ \_\_ \_\_ Eating disorder**; if yes, specify:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ \_\_ Blood pressure: High or Low **Circle One** \_\_ \_\_ \_\_ Gastrointestinal disease

\_\_ \_\_ \_\_ Pacemaker \_\_ \_\_ \_\_ Fainting spells or seizures

\_\_ \_\_ \_\_ Stroke \_\_ \_\_ \_\_ Venereal disease

\_\_ \_\_ \_\_ Mitral valve prolapse or heart murmur \_\_ \_\_ \_\_ Systemic lupus erythematosus

\_\_ \_\_ \_\_ Chest pain upon exertion \_\_ \_\_ \_\_ Rheumatic Fever

\_\_ \_\_ \_\_ Diabetes \_\_ \_\_ \_\_ Pain in the jaw joints TMJ/TMD

\_\_ \_\_ \_\_ **Type I\_\_\_** (insulin dependent) or\_\_\_**Type II** \_\_ \_\_ \_\_ Shingles

\_\_ \_\_ \_\_ Thyroid Problems: Hyper or Hypo **Circle One** \_\_ \_\_ \_\_ Ulcers

\_\_ \_\_ \_\_ Hemophilia \_\_ \_\_ \_\_ Blood Transfusion

\_\_ \_\_ \_\_ Dry mouth \_\_ \_\_ \_\_ Epilepsy

\_\_ \_\_ \_\_ Hepatitis, jaundice, or liver disease \_\_ \_\_ \_\_ Scarlet fever

\_\_ \_\_ \_\_ Recurrent infections, **if yes, specify: ­­\_\_**\_\_ \_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Over the counter drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**