www.dentalcorner.net

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Medical & Dental History Form

Patient Name: Hopkins (Last) | Joe (First) | E (MI) | (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Are you currently taking any prescription or non-prescription medications? If so, please list.

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

Please indicate if you have experienced any of the following:

- [ ] AMOXICILLIN ALLERGY
- [ ] ANEMIA
- [ ] ANESTHETIC ALLERGY
- [ ] ARTHRITIS
- [ ] ARTIFICIAL HEART VAL
- [ ] ARTIFICIAL JOINT REP
- [ ] ARTIFICIAL JOINTS
- [ ] ASPIRIN ALLERGY
- [ ] ASTHMA
- [ ] BLOOD DISEASE
- [ ] BLOOD THINNERS
- [ ] CANCER TREATMENT
- [ ] CANCER
- [ ] CHEMO THERAPY
- [ ] CODEINE ALLERGY
- [ ] COPD
- [ ] DIABETES
- [ ] EMPHYSEMA
- [ ] EPILEPSY
- [ ] ERYTHROMYCIN ALLERGY
- [ ] EXCESSIVE BLEEDING
- [ ] FRUIT ALLERGIES
- [ ] GLAUCOMA
- [ ] HAY FEVER
- [ ] HEAD INJURIES
- [ ] HEART DISEASE
- [ ] HEART MURMUR
- [ ] HEART TROUBLE
- [ ] HEPATITIS A
- [ ] HEPATITIS B
- [ ] HEPATITIS C
- [ ] HIGH BLOOD PRESSURE
- [ ] HIV
- [ ] IODINE ALLERGY
- [ ] JAUNDICE
- [ ] KEFLEX ALLERGY
- [ ] KIDNEY DISEASE
- [ ] LATEX ALLERGY
- [ ] LIVER DISEASE
- [ ] LORTAB ALLERGY
- [ ] MITRAL VALVE
- [ ] MORPHINE ALLERGY
- [ ] NERVOUS DISORDERS
- [ ] OSTEOPOROSIS
- [ ] OTHER
- [ ] PACEMAKER
- [ ] PENICILLIN ALLERGY
- [ ] PERCODAN ALLERGY
- [ ] PREDNISONE ALLERGY
- [ ] PREGNANCY
- [ ] PREMEDICATE
- [ ] PSYCHIATRIC TREATMNT
- [ ] RADIATION TREATMENT
- [ ] RESPIRATORY PROBLEMS
- [ ] RHEUMATIC FEVER
- [ ] RHEUMATISM
- [ ] SINUS PROBLEMS
- [ ] STOMACH PROBLEMS
- [ ] STROKE
- [ ] SULFA ALLERGY
- [ ] TUBERCULOSIS
- [ ] TUMORS
- [ ] ULCERS
- [ ] VENEREAL DISEASE

Are you pregnant?

◯ Yes ◯ No

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

Please mark any of the following to indicate Yes in response to the question:

- [ ] Do your gums bleed when you brush or floss?
- [ ] Do your teeth experience sensitivity to cold or hot temperatures?
- [ ] Are any of your teeth currently causing you pain?
- [ ] Do you grind your teeth (either consciously or during sleep)?
- [ ] Are any of your teeth loose, or are you concerned about any teeth loosening?
- [ ] Do you currently have any dental implants, dentures, or partials?
- [ ] Have you ever had periodontal treatment?
- [ ] Do you have a mouth odor or bad taste in your mouth?
- [ ] Do you have a fear of dental treatment?
- [ ] Do you have any immediate relatives that have lost all their natural teeth?
- [ ] Have you ever had orthodontic treatment?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

Signature of patient, parent, or guardian:

Signature: _____ Date:

Relationship to Patient:

FOR OFFICE USE ONLY

Doctor's Notes/Comments:

Response Date: 08/03/2017