

Medical & Dental History Form

Patient Name:

Last First 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:

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

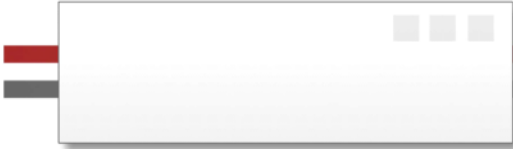
- 1 (+) a day 2 - 6 weekly 1 - 6 monthly Seldom Never

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 dental 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:

