

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: _____

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?
- Are you currently taking any prescription or non-prescription medications?
- 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?

WOMEN ONLY: Are you pregnant? _____

Please indicate if you have experienced any of the following:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Anxiety Attacks |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Bisphosphonates |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Clindamycin Allergy | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Epinephrine Sensitiv | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Fosamax | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> HPV | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Mitral Valve Prolaps | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> No Corticosteroids |
| <input type="checkbox"/> Novacaine Allergy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Plavix | <input type="checkbox"/> Pre-Med | <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"/> Valium Allergy | <input type="checkbox"/> Venereal Disease |

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Do you have any other health issues or allergies?

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

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

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?

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.

Signature of patient, parent, or guardian:

Signature _____ Date _____

Relationship to Patient:

Response Date: ___/___/___