Medical and Dental Health History Form

Date: _____

Patient name (first and last): _____

Name of previous dentist/location: _____

Date of last dental examination: _____

Date of last cleaning: _____

Why have you come to see us today (e.g. pain, checkup, etc.)? _____

_____

_____

Name and contact information for family physician: _____

Dental Health:

Yes	No	
☐	☐	Do you brush your teeth? How often? _____
☐	☐	Do you floss? How often? _____
☐	☐	Are you having any pain or discomfort at this time?
☐	☐	Do your gums bleed while brushing and flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Have you ever experienced any of the following problems with your jaw?

(Circle all that apply): clicking pain difficulty in opening and closing difficulty in chewing

☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth? If yes, when? _____
☐	☐	Have you ever had any orthodontic treatment? If so, do you wear a retainer? _____ _
☐	☐	Have you ever had facial surgery? If so, when and what area of your face?
		_____
☐	☐	Have you ever had any type of trauma to your mouth, jaw or face? If yes, describe:
_____		_____
☐	☐	Do you wear dentures or partials? If so, date of placement: _____
☐	☐	Do you have any concerns about bad breath odor?
☐	☐	Are you pleased with the appearance of your teeth when you smile?
☐	☐	Are you pleased with the color of your teeth?
☐	☐	Is there any dental treatment you are not happy with?
☐	☐	Are you nervous about dental treatment?

Medical Health:
Are you allergic or have you reacted adversely to any of the following (check all that apply):

____ _Aspirin
____ _Codeine
____ _Nitrous Oxide
____ _Penicillin
____ _Erythromycin
____ _Other antibiotics _____
____ _Latex, Metals, Plastic

___ Ibuprofen
___ Sulfa Drugs, Sulfites, Sulfides
___ Acetaminophen/Tylenol
___ Barbiturates
___ Tetracycline
___ Local Anesthesia (Novocaine)

Please list any other allergies to include medications you are allergic to:

Check any of the following that you have had or have at the present:

____ _Osteoporosis
____ _Heart disease or heart attack
____ _Abnormal blood pressure
____ _Heart murmur/mitral valve prolapse
____ _Rheumatic fever
____ _Heart pacemaker
____ _Heart surgery
____ _Stroke
____ _Kidney disease
____ _History of drug addiction /alchoholism
____ _Arthritis
____ _Anemia
____ _Bleeding disorders
____ _Hay fever
____ _Ulcers
____ _Jaundice
____ _Herpes
____ _Tumor or malignancy
____ _Radiation treatment
____ _Blood transfusion
____ _Fainting
____ _Headaches
____ _Glaucoma
____ _Shingles

___ Bisphosphonate therapy (e.g. Boniva)
___ Asthma
___ Diabetes
___ Thyroid issues
___ Hepatitis A, B, C
___ Hemophilia
___ Epilepsy or seizures
___ Psychiatric treatment
___ Artificial joints
___ Anemia
___ AIDS or HIV+
___ Congenital heart lesions
___ Tuberculosis or lung disease
___ Sinus issues
___ Liver disease
___ Infectious mononucleosis (mono)
___ Sexually transmitted/venereal disease
___ Cancer/chemotherapy/radiation
___ Implants/artificial joints
___ Anaphylaxis
___ Allergies (including food)
___ Hard of hearing
___ Sickle cell disease/traits

Other: _____

_____ _

Major surgeries (type and year): _____

_____ _

_____ _

_____

List sports activities: _____

_____

_____

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements. (An example is listed below.)

Name of medication	Dosage in mg.	Number of times taken	When (daily, as needed)
i.e. Aleve	275	2x	daily

Yes	No	
☐	☐	Have you been hospitalized during the past two years?
☐	☐	Have you been asked by your medical doctor to premedicate before any dental treatment?
☐	☐	Have you taken Fen-Phen, Redux or appetite suppressants? If yes, have you seen a physician for a cardiac evaluation?
☐	☐	Do you have any disease, condition or problem not listed?
☐	☐	Do you smoke or use chewing tobacco?
☐	☐	Do you smoke or ingest marijuana?
☐	☐	Do you drink alcohol? If yes, how often and in what quantity?

For Women Only:

Yes	No	
☐	☐	Are you pregnant? If yes, due date: _____
☐	☐	Are you taking birth control pills?
☐	☐	Could you be pregnant?
☐	☐	Are you nursing?
☐	☐	Hormone replacement?

This form is designed to solicit information typically required to plan treatment. The space below is for you to tell me other information you believe I should take into account when planning your treatment.

In the event of an emergency please contact:

Name: Relationship:_____ _____

Phone:

If you have any questions about this form or are unsure how to answer any questions, we'd be happy to assist you, please ask!

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signed: Date: _____

Patient Review and Update of Form: At each visit please review this form, note any changes, sign and date in the spaces below:
