

Medical and Dental Health History

(Confidential)

Date _____

Patient Name _____
Last First Middle

Birthdate _____

PLEASE READ CAREFULLY

Welcome to our office. We strive to provide for you the most thorough and individualized treatment possible within our scope of care. So that we may do this, we would appreciate your time and careful attention to the health and dental history. PLEASE REMEMBER that your past health history is as important as your current health status. If you have any questions or need help filling this out, please do not hesitate to ask. Thank you.

Medical History

Physician's Name _____ Last Seen _____

Address _____ Phone _____

Are you currently under the care of a Physician? _____

Previous Dentist _____ Last Seen _____

Have you had or do you currently have (Check all that apply):

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> By-Pass Surgery | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> ___ Insulin | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> ___ Oral Rx | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> ___ Diet | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems- Allergies/Hay Fever |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> ___ A | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Bone/Joint Disorders | <input type="checkbox"/> Frequent Cold/Sore Throat | <input type="checkbox"/> ___ B | <input type="checkbox"/> Strokes "Mini" (T.I.A.'s) |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> ___ C | <input type="checkbox"/> Surgeries (List Below) |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> HIV Positive <input type="checkbox"/> AIDS | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> ___ Artificial Heart Valves | <input type="checkbox"/> Implants | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> ___ Atrial Fibrillation | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> ___ Angioplasty | <input type="checkbox"/> Kidney Dialysis | <input type="checkbox"/> Tumors, Growths, or Malignancies |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> ___ Congestive Heart Failure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> ___ Irregular Heartbeat | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> ___ Slow ___ Rapid | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Syphilis ___ Gonorrhea |
| | | <input type="checkbox"/> Yeast Infections ___ Reoccurring? | <input type="checkbox"/> Herpes ___ Chlamydia |

Women

Are you Pregnant? Yes No

Are you taking birth control pills? Yes No

Are you taking hormone replacement therapy? Yes No

Surgeries (List any surgeries)

Allergies or Reactions To (Check all the apply):

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Morphine | _____ |
| <input type="checkbox"/> Barbituates, Sedatives, | <input type="checkbox"/> Penicillin | _____ |
| Sleeping Pills, Epinephrine | <input type="checkbox"/> Sulfa Drugs | _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Ibuprofen (Advil) | _____ |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Nickel | _____ |

Medications (List all Prescription & Non-Prescription)

(Continued on Other Side)

Dental History

Date of Last Dental X-rays: _____

Any trouble associated with previous dental treatment? (If yes, describe) _____

Any discomfort in your mouth at this time (If yes, describe)

Any injury or trauma to head or neck? _____

Any sensitivities to temperature, sweets, or pressure? _____

Do you have or have you had any blisters, swellings, or sores on you gums, cheeks, or lips? _____

Have you ever had T.M.J problems? _____ Do you clench or grind your teeth? _____

Have you had your teeth straightened (Orthodontics)? _____

Have you had gum surgery (Periodontics)? _____

Have you ever had a gum infection, pyorrhea or trenchmouth? _____

Have you ever had oral surgery? _____

Do your gums bleed when you brush or eat? _____

Do you clean between your teeth? With what? _____

What type of bristles are in your toothbrush(Soft/Medium/Hard)? _____

Do you have any disease, condition, or problem not listed above? If so, explain: _____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____