



Medical and Dental History

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact: _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you receive. We thank you for your cooperation in answering the following questions.

Are you currently under a physician's care (family doctor /specialist) YES NO
Doctor's name and phone number: _____

Are you taking any medication, vitamins or herbal supplements? YES NO
If yes, please list: _____

Pharmacy name and phone number: _____

Have you ever been hospitalized or had a major operation? YES NO
If yes, please explain: _____

Have you ever had a serious head, neck or jaw injury? YES NO
If yes, please explain: _____

Are you on a special diet? YES NO

Do you smoke, chew tobacco or use controlled substances? YES NO

Women: Are you pregnant? YES NO Due Date: _____

Taking Contraceptives? YES NO

Are you allergic to any of the following?

Aspirin Penicillin Sulfa Drugs Codeine Local Anesthetic

Acrylic Metal Latex

Other? Please explain: _____

Do you have, or have you ever had, any of the following? Check all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Allergies/ Anaphylaxis | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> Asthma/Breathing problems | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Congenital Heart Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Attack/Failure/ Angina |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis A, B or C |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Stomach/Intestinal/Ulcer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tumors or Growth |
| <input type="checkbox"/> Fainting spells/Dizziness | | |

Have you ever had any conditions or diseases not listed above? _____

When/where was your last dental visit? _____

When did you last have x-rays? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Are you nervous during dental appointments? Yes No

Are you currently experiencing any dental problems/concerns? Yes No

If yes, please explain: _____

Are your teeth sensitive to hot/cold? Yes No If yes, where?: _____

Are your teeth sensitive to biting/chewing/sweets? Yes No If yes, where?: _____

Have you ever had (check all that apply): Braces Oral surgery Dental implants Gum surgery

Have you ever, or do you currently (check all that apply): Grind/clench your teeth Chew gum

Bite your cheeks/nails Breathe through your mouth Suck finger/thumb Eat candy Drink pop

To the best of my knowledge the above information has been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any medical changes.

Signature of Patient/ Parent/ Guardian

Date

Signature of Dental Provider