

Medical History

Version: 08/04/2024

Patient Name:

Birth Date:

Today's Date:

Dental treatments treat the area in and around your mouth. However, health problems that you may have, or medication that you may be taking, could have an interaction with the dental care you will receive. Thank you for answering the following questions.

Are you under a physician's care currently?

Yes No

If yes,

Have you ever been hospitalized or had a major operations

Yes No

If yes,

Have you ever had a serious head or neck injury?

Yes No

If yes,

Are you taking any medications, pills, or drugs?

Yes No

If yes,

Have you ever taken any medications for osteoporosis or osteopenia?

Yes No

If yes,

Do you use tobacco?

Yes No

If yes,

Do you use controlled substances?

Yes No

If yes,

Do you use alcohol?

Yes No

If yes,

Women: Are you...

Pregnant

Nursing

Taking oral contraceptives

Trying to get pregnant

Are you allergic to any of the following?

Aspirin

Amoxicillin

Acrylic

Codeine

Clindamycin

Latex

Local Anesthetics

Metal

Penicillin

Sulfa Drugs

Other, if yes,

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Do you have, or have you ever had, any of the following?

Acid Reflux/ GERD	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
ADD/ADHD	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Loss of Limb	<input type="radio"/> Yes <input type="radio"/> No
Addiction(Alcohol)	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No
Addiction(Drugs)	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Lymes Disease	<input type="radio"/> Yes <input type="radio"/> No
AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Measles/ Mumps	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/ Dizzy	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Neck Problems	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No
Arthritis (Rheumatoid)	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Arthritis (Osteoarthritis)	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Gout	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pulmonary Issues	<input type="radio"/> Yes <input type="radio"/> No
Asperger's Syndrome	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/ Failure	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Autism	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Back Problems	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/ Disease	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Sjogren's Syndrome	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis C	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Herpes (Genital)	<input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Herpes (Oral)	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Stomach/ Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Circulatory Problems	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Stomach Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/ Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Immunosuppression	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Coronary Artery Disease	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No

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Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Jaundice	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Diabetes (Type 1)	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Unexplained Weight Change	<input type="radio"/> Yes <input type="radio"/> No
Diabetes (Type 2)	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Have you had any other serious illness not listed? <input type="radio"/> Yes <input type="radio"/> No If yes,					

Dental History:

Reason for today's visit:

Do you have any dental complaints, pain, or concerns? Yes No

Do your gums bleed when brushing or flossing? Yes No

Are your teeth sensitive to sweets, pressure, cold, or heat? Yes No

Are your teeth sensitive to chewing or biting? Yes No

Do you clench or grind your teeth at night? Yes No

J c x g " { q w j c f " c p { " r g t k f q p v e i " * i w o + " t g c v o g p v u A Yes No

J c x g " { q w j c f " c p { " q t v j q f q p v e " * d t c e g u + " t g c v o g p v u A Yes No

F q " { q w y g e t " f g p w t g u " q t " r c t v e n d e n t u r e s ? Yes No

Do you have sores or ulcers in your mouth? Yes No

Is your mouth dry? Yes No

Do you want to change your smile? Yes No

Additional Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my or a patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____