

Medical and Dental Health History Form

Getting to Know You As Our Patient

Account number: _____

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):

- | | |
|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa Drugs, Sulfites, Sulfides |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Acetaminophen/Tylenol |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Other antibiotics _____ | <input type="checkbox"/> Local Anesthesia (Novocaine) |
| <input type="checkbox"/> Latex, Metals, Plastic | |

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

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

- | | |
|--|--|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bisphosphonate therapy (e.g. Boniva) |
| <input type="checkbox"/> Heart disease or heart attack | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Abnormal blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart murmur/mitral valve prolapse | <input type="checkbox"/> Thyroid issues |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Artificial joints |
| <input type="checkbox"/> History of drug addiction /alcoholism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS or HIV+ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital heart lesions |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Tuberculosis or lung disease |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sinus issues |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Infectious mononucleosis (mono) |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Sexually transmitted/venereal disease |
| <input type="checkbox"/> Tumor or malignancy | <input type="checkbox"/> Cancer/chemotherapy/radiation |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Implants/artificial joints |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergies (including food) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hard of hearing |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> 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. (Two examples are listed below.)

Name of medication	Dosage in mg.	Number of times taken	When (daily, as needed)
i.e. Aleve	275	2x	daily
i.e. Viagra	50	1x	as needed

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? _____
- Do you take Viagra?

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:

Instructions for the use of this form:

- Members can tailor it to fit their practice.
- They can personalize by adding their practice name, address, phone and logo.
- To be completed by every new patient and maintained in the patient record for as long as the patient record is retained.
- Recommended that the patient review it at least annually, mark up any changes, and initial/date it. Best practices would dictate that it be reviewed and updated by the patient at each visit.
- Have patient complete a new one when the current one is illegible due to numerous updates.
- Retain old copies in treatment file.