MEDICAL/DENTAL HISTORY FORM

Soc. Sec. # _____ Date: _____

Driver's Lic.# _____ Birth Date: _____

Patient's Name: _____ Age: _____ Sex: _____ Marital Status: _____
Last First Middle

What is your reason for seeking dental treatment?

☐ Checkup for all necessary dental care ☐ Dental care for a specific problem

Explain _____

_____

Name of Physician _____ Address _____ Phone _____

Name of Previous Dentist _____ Address _____ Phone _____

Were Oral X-Rays taken? _____ Yes _____ No How Long Ago? _____

Please Answer All Questions

1. Are you under a physician's care now? ☐ Yes ☐ No
2. Have you been hospitalized or had a serious illness within the past 5 years? ☐ Yes ☐ No
3. Date of last medical examination: _____
4. Are you pregnant? _____ How many weeks? _____
5. Have you had any complications with past pregnancies? ☐ Yes ☐ No
6. Are you taking any medications or drugs at present? ☐ Yes ☐ No
   If so, please list them in space at bottom of page.

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

7. Heart disease ☐ Yes ☐ No
8. Shortness of breath with limited activity or when resting ☐ Yes ☐ No
9. Chest pain or angina pectoris ☐ Yes ☐ No
10. Heart attack ☐ Yes ☐ No
11. Mitral valve prolapse ☐ Yes ☐ No
12. Rheumatic fever or rheumatic heart disease ☐ Yes ☐ No
13. Heart murmur ☐ Yes ☐ No
14. Heart defect from birth ☐ Yes ☐ No
15. High blood pressure ☐ Yes ☐ No
16. Stroke ☐ Yes ☐ No
17. Fainting spells, convulsions or epilepsy ☐ Yes ☐ No
18. Nervous breakdown or emotional problems ☐ Yes ☐ No
19. Lung disease (T.B., asthma, emphysema or other) ☐ Yes ☐ No
20. Liver disease (jaundice, cirrhosis or other) ☐ Yes ☐ No
21. Hepatitis (A, B, C) ☐ Yes ☐ No
22. Kidney disease ☐ Yes ☐ No
23. Diabetes ☐ Yes ☐ No
24. Prolonged bleeding following injuries or surgery ☐ Yes ☐ No
25. Blood disorder ☐ Yes ☐ No
26. Venereal disease (syphilis, gonorrhea); Herpes ☐ Yes ☐ No
27. A.I.D.S./HIV ☐ Yes ☐ No
28. Arthritis ☐ Yes ☐ No
29. X-ray treatments or radiation therapy ☐ Yes ☐ No
30. Treatment for a tumor or growth ☐ Yes ☐ No
31. Do you have any limitations regarding activity or diet? ☐ Yes ☐ No
    If so, what? _____
32. Have you had joint surgery or a prosthetic joint replacement? ☐ Yes ☐ No
33. Headaches, neckaches, backaches? ☐ Yes ☐ No

Have you become sick from, shown any allergy to, or been told not to take the following:

34. Penicillin or other antibiotics ☐ Yes ☐ No
35. Aspirin, codeine or other pain medications ☐ Yes ☐ No
36. Novocaine, xylocaine, or other anesthetics ☐ Yes ☐ No
37. Other medications _____
38. Is there anything of importance in your medical history that has not been asked? ☐ Yes ☐ No
    Explain _____

39. Do you have problems with any of the following?
    Check those that apply.
    - ☐ Pain in teeth or gums
    - ☐ Pain or noise in jaw joint
    - ☐ Pain in jaws
    - ☐ Sores on lips/on mouth
    - ☐ Food sticking between teeth
    - ☐ Bleeding gums when flossing
    - ☐ Bleeding gums when brushing
    - ☐ Sensitivity to hot/cold/sweet
    - ☐ Pain in head/neck
    - ☐ Swelling
    - ☐ Loose teeth
    - ☐ Bad breath
    - ☐ Dentures/bridges
40. Have you ever had:
    Tooth extraction? _____ Oral Surgery? _____ Any difficulty? _____
    Periodontal (gum) surgery? _____ Injury to jaws/teeth? _____
41. Have you ever had problems in connection with the above?
    Excessive or prolonged bleeding _____ Delayed healing _____
42. Have you ever had:
    Orthodontic treatment? _____ Oral hygiene instruction? _____
43. Have you ever had:
    Removable dentures/bridges/appliances? _____
    Spare denture(s) _____
    Soreness/looseness with your denture(s)? _____
44. Have you ever had an unusual reaction to any dental treatment? ☐ Yes ☐ No
    Explain _____

Medications Currently Being Used (include prescription and non-prescription drugs, herbal medicines, diet pills, potency medications, etc.):

_____

_____

Medical History Updates (include recent hospitalizations): _____

_____

_____

_____

Blood Pressure: _____ Pulse: _____

_____ _____
Patient or Parent/Guardian Signature **Date**

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