

**MEDICAL HISTORY (Rev. 2012)**

PATIENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

*Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 will receive. Thank you for answering the following questions.*

Please circle to the answers to the following questions:

Are you currently under a physician's care? Yes No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a serious head or neck injury? Yes No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, dates of use: \_\_\_\_\_

Are you on any special diets? Yes No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you use tobacco product? Yes No If yes, please list type and duration: \_\_\_\_\_

Do you use controlled substances? Yes No If yes, please list type and duration: \_\_\_\_\_

Do you consume alcohol? Yes No If yes, please list type and duration: \_\_\_\_\_

Have you ever been treated/evaluated for sleep apnea? Yes No If yes, when and by whom: \_\_\_\_\_  
\_\_\_\_\_

Do you currently wear a C-PAP device? Yes No If yes, how often do you use the device? \_\_\_\_\_  
and when was the mask last fitted and by whom? \_\_\_\_\_

Are you taking any medications or supplements, either prescribed or over the counter? Yes No  
If yes, please list type, dosage, duration: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any of the following? If yes, please mark as indicated:

\_\_\_ Aspirin    \_\_\_ Penicillin    \_\_\_ Codeine    \_\_\_ Sulfa    \_\_\_ Local Anesthetics  
\_\_\_ Acrylic    \_\_\_ Metal    \_\_\_ Latex    \_\_\_ Other \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

*Do you have, or have you ever had any of the following? If yes, please explain to include dates and types of treatment.*

- Aids/ HIV Positive       YES    NO   \_\_\_\_\_
- Alzheimer's Disease     YES    NO   \_\_\_\_\_
- Anemia                     YES    NO   \_\_\_\_\_
- Angina                     YES    NO   \_\_\_\_\_
- Arthritis                  YES    NO   \_\_\_\_\_
- Artificial Heart Valve    YES    NO   \_\_\_\_\_
- Asthma                     YES    NO   \_\_\_\_\_
- Blood Disease             YES    NO   \_\_\_\_\_
- Blood Transfusion       YES    NO   \_\_\_\_\_
- Breathing Problem       YES    NO   \_\_\_\_\_
- Bruise Easily             YES    NO   \_\_\_\_\_
- Cancer                     YES    NO   \_\_\_\_\_
- Chemotherapy           YES    NO   \_\_\_\_\_
- Chest Pains               YES    NO   \_\_\_\_\_
- Cold Sores/Fever Blisters  YES    NO   \_\_\_\_\_
- Congenital Heart  
Disorder                  YES    NO   \_\_\_\_\_
- Convulsions               YES    NO   \_\_\_\_\_
- Cortisone Medication    YES    NO   \_\_\_\_\_
- Diabetes                   YES    NO   \_\_\_\_\_
- Drug Addiction           YES    NO   \_\_\_\_\_
- Easily Winded            YES    NO   \_\_\_\_\_
- Emphysema                YES    NO   \_\_\_\_\_
- Epilepsy of Seizures     YES    NO   \_\_\_\_\_
- Excessive Bleeding       YES    NO   \_\_\_\_\_
- Fainting Spells/ Dizziness  YES    NO   \_\_\_\_\_
- Frequent Cough           YES    NO   \_\_\_\_\_
- Frequent Diarrhea        YES    NO   \_\_\_\_\_
- Frequent Headaches      YES    NO   \_\_\_\_\_
- Genital Herpes           YES    NO   \_\_\_\_\_
- Glaucoma                  YES    NO   \_\_\_\_\_
- Gout                       YES    NO   \_\_\_\_\_
- Hay Fever                 YES    NO   \_\_\_\_\_
- Heart Attack/Failure     YES    NO   \_\_\_\_\_
- Heart Murmur             YES    NO   \_\_\_\_\_
- Heart Pace Maker        YES    NO   \_\_\_\_\_
- Heart Trouble/Disease    YES    NO   \_\_\_\_\_
- Hemophilia                YES    NO   \_\_\_\_\_
- Hepatitis A , B, or C     YES    NO   \_\_\_\_\_
- Herpes                     YES    NO   \_\_\_\_\_
- High Blood Pressure     YES    NO   \_\_\_\_\_
- Hives or Rash             YES    NO   \_\_\_\_\_
- Hypoglycemia             YES    NO   \_\_\_\_\_
- Irregular Heartbeat      YES    NO   \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

- Kidney Problems             YES    NO   \_\_\_\_\_
- Leukemia                     YES    NO   \_\_\_\_\_
- Liver Disease               YES    NO   \_\_\_\_\_
- Low Blood Pressure        YES    NO   \_\_\_\_\_
- Lung Disease                YES    NO   \_\_\_\_\_
- Mitral Valve Prolapse      YES    NO   \_\_\_\_\_
- MRSA                         YES    NO   \_\_\_\_\_
- Pain in Jaw Joints          YES    NO   \_\_\_\_\_
- Parathyroid Disease        YES    NO   \_\_\_\_\_
- Psychiatric Care           YES    NO   \_\_\_\_\_
- Radiation Treatments      YES    NO   \_\_\_\_\_
- Recent Weight Loss        YES    NO   \_\_\_\_\_
- Renal Dialysis              YES    NO   \_\_\_\_\_
- Rheumatic Fever           YES    NO   \_\_\_\_\_
- Rheumatism                 YES    NO   \_\_\_\_\_
- Scarlet Fever               YES    NO   \_\_\_\_\_
- Shingles                     YES    NO   \_\_\_\_\_
- Sickle Cell Disease        YES    NO   \_\_\_\_\_
- Sinus Trouble               YES    NO   \_\_\_\_\_
- Sleep Apnea                 YES    NO   \_\_\_\_\_
- Spina Bifida                YES    NO   \_\_\_\_\_
- Stomach/Intestinal  
Disease                     YES    NO   \_\_\_\_\_
- Stroke                       YES    NO   \_\_\_\_\_
- Swelling of Limbs          YES    NO   \_\_\_\_\_
- Thyroid Disease            YES    NO   \_\_\_\_\_
- Tonsillitis                  YES    NO   \_\_\_\_\_
- Tuberculosis                YES    NO   \_\_\_\_\_
- Tumors/Growths            YES    NO   \_\_\_\_\_
- Ulcers                       YES    NO   \_\_\_\_\_
- Venereal Disease          YES    NO   \_\_\_\_\_
- Yellow Jaundice           YES    NO   \_\_\_\_\_

Have you had any serious illnesses not listed above?   Y   N   If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PATIENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

**DENTAL HISTORY**

When was the date of your last dental visit? \_\_\_\_\_

What was the reason for your last dental visit? \_\_\_\_\_

Do you wear a night guard? YES NO If yes, how old is the device? \_\_\_\_\_

Have you ever had Orthodontic treatment? YES NO If yes, when was the treatment completed: \_\_\_\_\_  
Who was the treating specialist? \_\_\_\_\_

Have you ever had Periodontal Surgery/Therapy? YES NO If yes, when was the treatment completed: \_\_\_\_\_  
Who was the treating specialist? \_\_\_\_\_

Have you ever taken antibiotics prior to dental treatment? YES NO If yes, please specify the reason: \_\_\_\_\_  
\_\_\_\_\_

Did you take antibiotics for today's visit? YES NO If yes, what type, dosage and time: \_\_\_\_\_  
\_\_\_\_\_

Are you currently in dental pain/discomfort? YES NO If yes, please describe the location and duration: \_\_\_\_\_  
\_\_\_\_\_

Does the discomfort wake you at night? YES NO

Do you experience a high level of anxiety during dental treatment? YES NO If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like to discuss during your visit? YES NO If yes, please elaborate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*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 patient's) health. It is my responsibility to inform the dental office on any changes in medical status.*

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by Staff

\_\_\_\_\_  
Date

PATIENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

**To better coordinate your treatment please list the professionals you have consulted.**

**Primary Care Physician**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Chiropractor**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Cardiologist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Orthopedist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**ENT**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Physical Therapist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Allergist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Neurologist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Psychiatrist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Psychologist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Sleep Specialist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Other**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

***I understand and agree to have the indicated professionals I have listed above consulted regarding my treatment and prognosis as needed.***

Signature Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

