Medical/ Dental History

Today's Date _____

Name _____ Date of Birth ____/____/____ Home Phone # _____

Address _____ City, St., Zip_____ Cell Phone # _____

Business Address _____City, St., Zip_____ Phone# _____ E-Mail_____

Occupation_____ Social Security# _____ ( ) Male ( ) Female ( ) Married ( ) Single ( ) Minor

Emergency Contact_____ Relationship _____ Phone#_____

If you are completing this form for another person, what is your relationship? _____

Who is the person responsible for this account? _____ Dental Insurance? Yes No _____

Whom may we thank for referring you to this office? _____

Y N

___ ___ Has there been any change in your general health within the past year?_____
My last physical exam was on:_____

___ ___ Are you now under the care of a physician?
If so, what is the condition being treated? _____
The name, address and phone#
of my physician is: _____
_____

___ ___ Have you had any serious illness, hospitalization, or surgery? _____
If so, what is/was the condition treated? _____
_____

___ ___ Are you taking any medication(s), including non-prescription and/or vitamin supplements? _____
_____
_____

___ ___ Are you allergic to any medications? _____

___ ___ Have you been told you may need antibiotics prior to dental treatment? _____

Cardiovascular

___Congenital Heart Defects
___ Hear Murmur
___ Mitral Valve Prolapse
___ Rheumatic Heart Disease
___ Damaged Heart Valves
___Artificial Heart Valves
___ Heart Attack
___ Angina
___Coronary Insufficiency
___Coronary Occlusion
___High/ Low Blood Pressure
___High Cholesterol
___ Arteriosclerosis
___ Chest Pain w/ Exertion
___ Shortness of Breath
___ Swollen Ankles

Respiratory

___Asthma
___ Emphysema
___Bronchitis
___ Tuberculosis
___Persistent Cough
___Cough w/ Blood
___Allergy
___ Sinus Problems
___ Hay Fever
___Do You Smoke?

Gastrointestinal

___Diet (special/restricted)
___ Persistent Diarrhea
___Recent Weight Loss/Gain
___ Ulcers
___ Hyperacidity/Acid Reflux

Endocrine/Renal

___ Urinate Frequently
___Consistently Thirsty
___ Frequent Dry Mouth
___ Diabetes
___ Hepatitis
___ Liver Disease
___ Jaundice
___ Cirrhosis
___ Alcohol Use
___ Thyroid Disorder

Ophthalmologic

___ Contact Lenses
___ Glaucoma

Dermatologic/Bone

___ Cold Sores
___ Canker Sores
___ Herpes
___ Rashes
___Hives
___Candidiasis(Yeast)
___ Arthritis
___ Painful Swollen Joints
___ Artificial Joints/ Prosthetics
___ Osteoporosis

Neurological/Psychiatric

___ Stroke
___ Epilepsy
___ Seizures
___ Dizziness
___ Depression/Anxiety

Medications (currently taking & why?)

Y N

___ ___ Antibiotics or sulfa drugs_____
___ ___ Anticoagulants (blood thinners) _____
___ ___ Medicine for high blood pressure _____
___ ___ Cortisone (steroids) _____
___ ___ Antidepressants/anti-anxiety drugs _____
___ ___ Aspirin _____
___ ___ Insulin, or other diabetes medications _____
___ ___ Digitalis, or other heart medications _____
___ ___ Nitroglycerin _____
___ ___ Other _____

Are you allergic or have you reacted adversely to:

___ ___ Local anesthetics (novocain) _____
___ ___ Penicillin or other antibiotics _____
___ ___ Sulfa drugs _____
___ ___ Barbiturates, sedatives, or sleeping pills _____
___ ___ Aspirin _____
___ ___ Iodine _____
___ ___ Latex_____
___ ___ Metals or jewelry _____
___ ___ Other _____

___ ___ Have you had surgery or any treatment for a tumor or growth? _____

___ ___ Have you had any serious trouble associated with any previous dental treatment? _____
If so, please explain. _____
_____

My last dental exam/visit was on: _____

___ ___ Do you have any condition NOT listed that we should know about? _____
_____
_____

Women

___ ___ Are you pregnant? If so, how many weeks? _____
___ ___ Are you nursing?
___ ___ Are you taking birth control pills?
___ ___ Have you gone through menopause?

I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the providing dentist or any other member of his staff responsible for any errors of omissions that I have made in the completion of this form.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

Summary of Pertinent Findings/Recommended Treatment Modifications (Dentist's Use Only)

_____
_____
_____
_____
_____
_____