MEDICAL HISTORY FORM

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Date _____

Name_____ Date of Birth _____/_____/_____ Sex ☐M ☐F
month day year

For the following questions, circle Yes or No, or fill in the blank, whichever applies.
Your answers are for our records only and will be confidential.

Yes No Are you in good health?
Yes No Has there been any change in your general health within the last year?
Yes No Are you now under the care of a physician?
* If so, what is the condition being treated?_____
* My last physical exam was on (approximate date) _____
* Name(s) of my physician(s) 1. _____ 2._____
Specialty _____ _____
Phone _____ _____
Yes No In the past 5 years, have you had any serious illness, operation, or been hospitalized?
* If so, please describe _____

Please list medications:
Prescriptions_____
Herbal remedies or supplements_____
Non-prescription meds_____

*Are you allergic or have you had a reaction to:

Yes No Aspirin
Yes No Metals of any kind
Yes No Iodine
Yes No Latex products
Yes No Penicillin or other antibiotics
Yes No Codeine or other narcotic
Yes No Local anesthetics
Yes No Other_____

*Do you have or have you had any of the following diseases or problems?

Yes No Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease?
Yes No Do you require Pre-medication?
Yes No Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, high blood pressure, arteriosclerosis, stroke)
Yes No Chest pain upon exertion
Yes No Cardiac pacemaker
Yes No Inborn heart defects
Yes No Sinus trouble
Yes No Asthma or hay fever (circle which one)
Yes No Tuberculosis
Yes No Fainting spells or seizures
Yes No Low blood pressure
Yes No Blood transfusion
Yes No Drug addiction
Yes No AIDS or HIV infection
Yes No Bruise easily or slow healing
Yes No Diabetes
Yes No Thyroid problems
Yes No Kidney problems
Yes No (Women) Are you pregnant?
Yes No Back Aches or Back Problems
Yes No Insomnia, sleep disorders
Yes No Shortness of breath (after mild exercise or when lying down)
Yes No Psychiatric Problems
Yes No Ankles that swell
Yes No Respiratory problems (emphysema, bronchitis, etc.)
Yes No Persistent cough or one that produces blood
Yes No Epilepsy or other neurological problem
Yes No Cancer, growth, or tumor
Yes No Persistent diarrhea or recent weight loss
Yes No Persistent swollen glands in neck
Yes No Hepatitis, jaundice, or liver disease
Yes No Sexually transmitted disease
Yes No Problems with the immune system
Yes No Anemia or other blood disorder
Yes No Stomach ulcer or hyperacidity
Yes No Cold sores (oral herpes)
Yes No Artificial joint or medical prosthesis
Yes No Bursitis or arthritis or joint pains
Yes No Do you use tobacco products?
Yes No Chemotherapy
Yes No Scarlet Fever

(over)

*Why are you now seeking dental treatment?_____

*Approximate date of last dental cleaning:_____ Dentist/City:_____

*Approximate date of last dental treatment:_____ Dentist/City:_____

Yes No Have you had any serious problems with previous dental treatment?

*If so, please explain _____

Yes No Are you worried about receiving dental treatment?

Yes No Would you like to change the appearance of your teeth in any way?

Yes No Would you like to have whiter teeth?

Yes No Do you feel you have bad breath?

Yes No For children under 12: Fluoride drops or tablets being taken?

*How often do you brush your teeth? _____ How often do you floss?_____

*Have you ever had:

Yes No Bleeding Gums

Yes No Injury to your face or jaws

Yes No Difficulty opening your mouth

Yes No Noises in the jaw joints

Yes No Pain with chewing or yawning

Yes No Uncomfortable or unusual bite

Yes No Headaches

Yes No Blisters/Sores in or around the mouth

Yes No Chronically dry mouth

Yes No Periodontal (gum) treatment, or advised to have such treatment

Yes No Teeth sensitive to heat, cold or sweets

Yes No Jaw gets “stuck”, “locked”, or “goes out”

Yes No Pain in or near the ears, temples or cheeks

Yes No Clenching or grinding of your jaws or teeth

Yes No Treatment for a jaw joint (TMJ) problem

Yes No Do you have any other comments or problem/disease not listed above?_____

_____

_____

To the best of my knowledge, all the preceding answers are correct. If I ever have any change in my health, or if my medicines change, I will inform my dentist at my next appointment.

Date *Signature of patient (Guardian or parent, if under 18)*

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For completion by the dentist or staff:

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Therapeutic alerts: _____

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