MEDICAL – DENTAL HISTORY

Patient's Name _____ **DOB** _____ **SSN** _____

INSTRUCTIONS: To receive treatment in this office you must answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in the office-to the best of your ability, honest answers must be given. If you are unsure of the questions, unsure of your answer, or whether the questions relate to your medical condition, you are to discuss the matter with the doctor. Some of the questions may not relate to your medical condition; in the event you are to write "N/A" (not applicable) in the space provided. All questions must be answered. To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information."Please sign it in the presence of a member of the office staff. ***ALL INFORMATIONS YOU SUPPLY ON THIS FORM OR INFORMATION OBTAINED BY YOUR PHYSICIAN AND THE SUBSEQUENT INTERVIEW BY THE DENTIST WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR WRITTEN PERMISSION.***

Name, address and telephone number of your physician _____

_____ _____

Date of last visit to your MD _____ **Purpose of visit** _____

Do you suffer from any disability? _____ **If yes, describe** _____

PLEASE CHECK EACH OF THE FOLLOWING: YES OR NO

YES	NO		YES	NO	
◯	◯	Rheumatic Fever	◯	◯	Cancer-Radiation/Chemotherapy
◯	◯	Joint Replacement (hip, knee etc)			(Please circle type of treatment)
◯	◯	Heart Murmur	◯	◯	Epilepsy/Seizures
◯	◯	Surgery (type _____ YR _____)	◯	◯	Fainting/Nervousness

○ ○ Arthritis/Rheumatism	○ ○ Heart Disease/Heart Attack,
○ ○ Mitral Valve Prolapse	○ ○ Angina, Pacemaker, Heart Surgery or Irregular beats
○ ○ Hepatitis/Liver disease Type? ☐ How long ago? ☐	○ ○ Herpes Virus
○ ○ HIV Positive/AIDS	○ ○ Asthma/Respiratory problems
○ ○ Migraine headache	○ ○ Diabetes (Type? ☐)
○ ○ Neck/Head Pain	○ ○ Stroke/Convulsions
○ ○ Anemia/Blood Disease	○ ○ STD/Venereal Disease
○ ○ Tuberculosis/Lung Disease	○ ○ Thyroid Disease
○ ○ Kidney Dysfunction/Disease/Dialysis	○ ○ Frequently Tired
○ ○ Hay Fever/Allergies	○ ○ Liver Disease
○ ○ Low Blood Pressure	○ ○ Pregnant? Of months ☐
○ ○ High Blood Pressure	○ ○ Are you Nursing?
○ ○ Do you use tobacco	○ ○ Are you taking Birth Control Pills?
○ ○ Implants (teeth, breast, hair, etc.)	○ ○ Other Medical Condition, past or present

(If yes, has your physician told you that premedication is needed prior to dental treatment?)

☐

Allergic to (Please circle all that apply): Aspirin ☐ codeine ☐ Local Anesthesia ☐ Penicillin ☐ Latex ☐

Sulfa ☐ Ibuprofen (Advil or Motrin) ☐ Other: ☐ No known allergies ☐

Date: ☐

Have you ever needed PRE ***MEDICATION*** (antibiotic) prior to dental treatment? ☐

☐

If you have answered yes to any of the above questions please explain:

Please list all medications, reason for taking them, mg. you are taking, and frequency taken

(Prescription and non-prescription)

DENTAL HISTORY

Name of the previous dentist Reason for visit

PLEASE CHECK EACH OF THE FOLLOWING: YES OR NO

YES	NO		YES	NO	
○	○	Had an allergic reaction to treatment?	○	○	Had abnormal bleeding?
○	○	Complications during treatment?	○	○	Do your gums bleed on brushing or eating?
○	○	Does food catch between your teeth?	○	○	Have your teeth shifted?
○	○	Do you grind your teeth or clench your jaws?	○	○	Are any of your teeth sensitive to hot, cold, or pressure?
○	○	Do your teeth ache?	○	○	Are there any sores or growths in your mouth?

If you have answered yes to any of the above questions please explain:

NOTE: A change in your health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners.

Person completing the form: Signature

Witness Print Name

If other than patient, indicate relationship Date