PATIENT MEDICAL HISTORY FORM

Name:________________________________ **Date:** ________________

The following information is to be reviewed by the doctor and will be held in strictest confidence. It is important that you complete this medical history form in its entirety so we may accurately diagnose and treat you, according to your general health and well-being.

If you have any questions or require assistance in completing this medical history form, please ask our staff to help. Please return this completed form to the receptionist. Thank you for allowing us to serve your dental health care needs.

Reason for your visit:________________________________

GENERAL MEDICAL HISTORY

	Yes	No
Are you currently in good health?	❑	❑
Are you currently under the care of a physician ? Why? ________________	❑	❑
Name, address, and phone# of your physician: ________________ ________________ ________________		
Date of last physical exam: ________________		
Have you been hospitalized or had a major illness, operation or injury in the last 5 years?	❑	❑
If yes, please explain: ________________ ________________		
Please list all medications you are currently taking, including over-the-counter drugs: ________________ ________________		
Allergies to anesthetics?	❑	❑
Are you allergic to latex?	❑	❑
Are you allergic to any metals?	❑	❑
Are you allergic to iodine?	❑	❑
Allergies to medicines or drugs? If yes, name them: ________________	❑	❑

	Yes	No
Have you been exposed to any of the following diseases?		
• AIDS	❑	❑
• Herpes	❑	❑
• Mononucleosis	❑	❑
• Respiratory illnesses (TB, Asthma)	❑	❑
• Hepatitis (any form)	❑	❑
Have you lost 10 or more pounds in the last 6 months without dieting?	❑	❑
Do you have any sores in your mouth or on other parts of your body?	❑	❑
Do you drink alcohol? If yes, how often? ________________	❑	❑
Do you use tobacco products? If so, how much? What form? ________________	❑	❑
Are you currently using unprescribed "street drugs"?	❑	❑
Do you get headaches frequently? If so, how often? ________________	❑	❑
What causes the headaches? ________ ________________		
* Women: Are you pregnant?	❑	❑
Are you nursing?	❑	❑

(Over)

Have you ever had or been treated for any of the following conditions or diseases?	Yes	No
AIDS/ARC/HIV	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Cancers	❑	❑
Circulatory problems	❑	❑
Diabetes	❑	❑
Diverticulitis/Colitis	❑	❑
Dizziness	❑	❑
Excessive Bleeding	❑	❑
Emotional/Mental disorders	❑	❑
Glandular/Endocrine/Thyroid Disorders	❑	❑
Glaucoma	❑	❑
Heart problems	❑	❑
High blood pressure	❑	❑
Kidney/bladder infection	❑	❑
Low blood pressure	❑	❑
Nervous disorders	❑	❑
Painful urination	❑	❑
Respiratory Disorders	❑	❑
Seizures	❑	❑
Shortness of breath	❑	❑
Sinus problems	❑	❑
Stroke	❑	❑
Tuberculosis	❑	❑
Ulcers	❑	❑
Other	❑	❑

If yes, please specify:

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	Yes	No
Have you ever been told you have a heart murmur or have you had rheumatic fever?	❑	❑
Do you have an artificial joint, heart valve, shunt, pacemaker or other prosthesis?	❑	❑
Have you taken steroids in the past year?	❑	❑

Please describe any current medical treatments, surgeries or any other medical or dental information that may affect your dental treatment.

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DENTAL HISTORY

	Yes	No
Do you have any unusual fear of dental treatment?	❑	❑
Have you ever experienced a problem with local anesthtics, such as novocaine or lidocaine?	❑	❑
Do you have pain/clicking when opening or closing your jaw?	❑	❑
Have you ever had TMJ treatment?	❑	❑
Do you have any discomfort in your mouth currently?	❑	❑

Are your teeth sensitive to heat? Cold? Sweets? Biting? (please circle)

	Yes	No
Have you ever had your teeth straightened?	❑	❑

How often do you brush your teeth? ______________

How often do you dental floss? ______________

	Yes	No
Have you ever been diagnosed as having periodontal disease?	❑	❑
Do you grind or clench your teeth?	❑	❑
Are you aware of any swelling or lump in your mouth?	❑	❑
Do your gums bleed when you brush your teeth?	❑	❑

Are you aware of any oral habits - (please circle) thumb sucking, nail biting, mouth breathing?

	Yes	No
Do you snore or have sleep apnea?	❑	❑

The information given about my health history in this form is accurate to the best of my knowledge. I hereby give my consent for necessary diagnostic tests (including X-rays) and evaluation of my dental health.

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Signature of patient, parent or guardian **Date**