Medical and Dental Health History Form

Today's Date: _____

Patient name (first and last): _____

Why have you come to see us today (e.g. pain, checkup, etc.)? _____

_____

_____

Name for family physician and/or other physician you are currently under the care of: _____

_____

Dental Health:

Yes	**No**	
☐	☐	Do you brush your teeth? How often? _____
☐	☐	Do you floss? How often? _____
☐	☐	Are you having any pain or discomfort at this time?
☐	☐	Do your gums bleed while brushing and flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Have you ever experienced any of the following problems with your jaw?

(Circle all that apply): clicking pain difficulty in opening and closing difficulty in chewing

☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth?
☐	☐	Have you ever had any orthodontic treatment? If so, do you wear a retainer? _____
☐	☐	Have you ever had facial surgery? If so, when and what area of your face?
		_____
☐	☐	Have you ever had any type of trauma to your mouth, jaw or face? If yes, describe:
		_____
☐	☐	Do you wear dentures or partials?
☐	☐	Do you have any concerns about bad breath odor?

Medical Health:

Are you allergic or have you reacted adversely to any of the following (check all that apply):

___ Aspirin
___ Codeine
___ Latex, Metals, Plastic
___ Penicillin
___ Erythromycin
___ Other antibiotics: _____
___ Ibuprofen
___ Sulfa Drugs, Sulfites, Sulfides
___ Acetaminophen/Tylenol
___ Barbiturates
___ Tetracycline
___ Local Anesthesia

Please list any other allergies, including food allergies: _____

Check any of the following that you have had or have at the present:

___ ADD / ADHD
___ AIDS / HIV
___ Alzheimer's Disease
___Anaphylaxis
___ Anemia_
___ Arthritis / Gout
___ Artificial Heart Valve
___ Artificial Joint: _____
___ Asthma
___Blood Disease
___ Blood Transfusion
___ Breathing Problems
___ Bruise Easily
___ Cancer: _____
___ Chemotherapy: _____
___Chest Pains
___ Cold Sores / Fever Blisters
___ Congenital Heart Disorder
___ Convulsions
___ Diabetes: Type I Type II
___ Drug / Alcohol Addiction
___ Easily Winded
___ Emphysema
___Epilepsy / Seizures
___ Excessive Bleeding
___ Fainting Spells / Dizziness
___ Frequent Cough
___Frequent Diarrhea
___Frequent Headaches
___ Genital Herpes
___ Glaucoma
___ Heart Attack / Failure: _____
___ Heart Murmur
___ Heart Pacemaker
___ Heart Trouble / Disease
___ Hemophilia
__ Hepatitis: A B C
__ Herpes
__ High Blood Pressure
__ High Cholesterol
__ Hives / Rash
__ Hypoglycemia
__ Irregular Heartbeat
__ Kidney Problems
__ Leukemia
__ Liver Disease
__ Low Blood Pressure
__ Lung Disease
__ Mitral Valve Prolapse
__ Osteoporosis
__ Pain in Jaw Joints
__ Parathyroid Disease
__ Psychiatric Care
__ Radiation Treatment: _____
__ Recent Weight Loss
__ Renal Dialysis
__ Rheumatic Fever
__ Rheumatism
___ Scarlet Fever
__ Shingles
__ Sickle Cell Disease
__ Sinus Trouble
__ Spina Bifida
__ Stomach / Intestinal Disease
__ Stroke: _____
__ Swelling of Limbs
__ Thyroid Disease
__ Tonsillitis
__ Tuberculosis
__ Tumors / Growth
__ Ulcers
__ Venereal Disease / STI 's

Other: _____

Major surgeries (type and year): _____

_____

_____

***Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements.**

_____

_____

_____

_____

_____

Yes	No	
☐	☐	Have you been hospitalized during the past two years?
☐	☐	Have you been asked by your Medical doctor to **PREMEDICATE** before any dental treatment?
☐	☐	Are you currently on **BLOOD THINNERS**?
☐	☐	Do you have any disease, condition or problem not listed? _____
☐	☐	Do you smoke, vape or use chewing tobacco?
☐	☐	Do you smoke or ingest marijuana?

For Women Only:

Yes	No	
☐	☐	Are you pregnant? If yes, due date: _____
☐	☐	Are you taking birth control pills?
☐	☐	Could you be pregnant or are you actively trying to get pregnant?
☐	☐	Are you nursing?
☐	☐	Are you currently taking any type of hormone replacement?

**** If you have any questions about this form or are unsure how to answer any questions, we'd be happy to assist you, please ask! ****

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signed: _____ Date: _____