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 that we may accurately diagnose and treat you, according to your general health and wellbeing.

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 this visit: _____

GENERAL MEDICAL HISTORY

	YES	NO
Are you presently in good health?	❑	❑
Are you presently under the care of a physician?	❑	❑
If yes, what is the condition or nature of illness?	❑	❑

_____

_____

Name 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?	❑	❑
Allergies to medicines or drugs? If yes, name them:	❑	❑

_____

_____

For women, only: Is there a possibility that you may be pregnant?	❑	❑

If yes, give due date:

_____

	YES	NO
Are you nursing?	❑	❑
Have you been exposed to any of the following diseases?		
• AIDS	❑	❑
• Herpes	❑	❑
• Mononucleosis	❑	❑
• Respiratory illnesses	❑	❑
• Hepatitis (any form)	❑	❑
Have you lost 10 or more pounds in the last 6 months without dieting?	❑	❑
Did you ever have a blood transfusion, particularly prior to March 1985?	❑	❑
Do you have any sores in your mouth or on other parts of your body?	❑	❑
Have you had sores in or around your mouth or on other part of your body in the past which occasionally return?	❑	❑
Do you drink alcohol? If yes, how often?	❑	❑

_____

Do you use tobacco products? If so, how much? What form?	❑	❑

_____

(Over)

Have you ever had or been treated for any of the following conditions or diseases?

	YES	NO
AIDS/ARC/HIV+	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Circulatory problems	❑	❑
Diabetes	❑	❑
Diverticulitis/Colitis	❑	❑
Dizziness	❑	❑
Excessive bleeding	❑	❑
Glaucoma	❑	❑
Heart problems	❑	❑
High blood pressure	❑	❑
Kidney/bladder infection	❑	❑
Low blood pressure	❑	❑
Malignancies (cancers)	❑	❑
Measles	❑	❑
Mumps	❑	❑
Nervous disorders	❑	❑
Painful urination	❑	❑
Rheumatic fever	❑	❑
Scarlet fever	❑	❑
Shortness of breath	❑	❑
Sinus problems	❑	❑
Stroke	❑	❑
Typhoid fever	❑	❑
Tonsillitis	❑	❑
Tuberculosis	❑	❑
Ulcers	❑	❑
Other	❑	❑

If yes, please specify:

_____

_____

_____

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

_____

_____

_____

DENTAL HISTORY

	YES	NO
Have you ever experienced a problem with local anesthesia?	❑	❑
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 presently?	❑	❑
Are your teeth sensitive to heat? Cold? Sweets?	❑	❑

If yes, please indicate which:

_____

Have you ever had your teeth straightened?	❑	❑
How often a day do you brush your teeth?	_____	
How often a day do you use dental floss?	_____	
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?		
Do you get frequent blisters on the lips or mouth?	❑	❑
Are you aware of any oral habits (thumb sucking, nail biting, mouth breathing, etc)?	❑	❑

If yes, please indicate:

_____

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

_____

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

Medical review: I have reviewed this medical history and have added any changes since my last visit.

_____

Signature **Date**