Medical and Dental Health History Form
Getting to Know You As Our Patient

Account number: _____

Date: _____

Patient name (first and last): _____

Name of previous dentist/location: _____

Date of last dental examination: _____

Date of last cleaning: _____

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

_____

_____

Name and contact information for family physician: _____

_____

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 bums 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? If yes, when? _____
☐	☐	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? If so, date of placement: _____
☐	☐	Do you have any concerns about bad breath odor?
☐	☐	Are you pleased with the appearance of your teeth when you smile?
☐	☐	Are you pleased with the color of your teeth?
☐	☐	Is there any dental treatment you are not happy with?
☐	☐	Are you nervous about dental treatment?

Medical Health:

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

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

Please list any other allergies to include medications you are allergic to: _____

_____

_____

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

___ Osteoporosis
___ Heart disease or heart attack
___ Abnormal blood pressure
___ Heart murmur/mitral valve prolapse
___ Rheumatic fever
___ Heart pacemaker
___ Heart surgery
___ Stroke
___ Kidney disease
___ History of drug addiction /alchoholism
___ Arthritis
___ Anemia
___ Bleeding disorders
___ Hay fever
___ Ulcers
___ Jaundice
___ Herpes
___ Tumor or malignancy
___ Radiation treatment
___ Blood transfusion
___ Fainting
___ Headaches
___ Glaucoma
___ Shingles
___ Bisphosphonate therapy (e.g. Boniva)
___ Asthma
___ Diabetes
___ Thyroid issues
___ Hepatitis A, B, C
___ Hemophilia
___ Epilepsy or seizures
___ Psychiatric treatment
___ Artificial joints
___ Anemia
___ AIDS or HIV+
___ Congenital heart lesions
___ Tuberculosis or lung disease
___ Sinus issues
___ Liver disease
___ Infectious mononucleosis (mono)
___ Sexually transmitted/venereal disease
___ Cancer/chemotherapy/radiation
___ Implants/artificial joints
___ Anaphylaxis
___ Allergies (including food)
___ Fainting
___ Hard of hearing
___ Sickle cell disease/traits

Other: _____

_____

Major surgeries (type and year): _____

_____

_____

_____

List sports activities: _____

_____

_____

_____

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements. (Two examples are listed below.)

Name of medication	Dosage in mg.	Number of times taken	When (daily, as needed)
i.e. Aleve	275	2x	daily
i.e. Viagra	50	1x	as needed

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?
☐	☐	Have you taken Fen-Phen, Redux or appetite suppressants? If yes, have you seen a physician for a cardiac evaluation? _____
☐	☐	Do you have any disease, condition or problem not listed? _____
☐	☐	Do you smoke or use chewing tobacco?
☐	☐	Do you smoke or ingest marijuana?
☐	☐	Do you drink alcohol? If yes, how often and in what quantity? _____
☐	☐	Do you take Viagra?

For Women Only:

Yes	No	
☐	☐	Are you pregnant? If yes, due date: _____
☐	☐	Are you taking birth control pills?
☐	☐	Could you be pregnant?
☐	☐	Are you nursing?
☐	☐	Hormone replacement?

This form is designed to solicit information typically required to plan treatment. The space below is for you to tell me other information you believe I should take into account when planning your treatment.

In the event of an emergency please contact:

Name: _____ Relationship: _____

Phone: _____

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: _____

Patient Review and Update of Form: At each visit please review this form, note any changes, sign and date in the spaces below:

Instructions for the use of this form:

- ☐ Members can tailor it to fit their practice.
- ☐ They can personalize by adding their practice name, address, phone and logo.
- ☐ To be completed by every new patient and maintained in the patient record for as long as the patient record is retained.
- ☐ Recommended that the patient review it at least annually, mark up any changes, and initial/date it. Best practices would dictate that it be reviewed and updated by the patient at each visit.
- ☐ Have patient complete a new one when the current one is illegible due to numerous updates.
- ☐ Retain old copies in treatment file.