

MEDICAL HISTORY

PATIENT NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No ☐ N/A _____Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ☐ N/A _____Have you ever had a serious head or neck injury? ☐ Yes ☐ No ☐ N/A _____Are you taking any medications, pills, or drugs? ☐ Yes ☐ No ☐ N/A _____Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No ☐ N/A _____Do you use tobacco? ☐ Yes ☐ No ☐ N/A _____Are you on a special diet? ☐ Yes ☐ No ☐ N/A Do you use controlled substances? ☐ Yes ☐ No ☐ N/A _____Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? _____

Are you allergic to any of the following? _____

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following? _____

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A _____Comments: _____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DATE _____

MEDICAL/DENTAL HEALTH UPDATE - Please verify changes in your health status at regular intervals

Date	Change In Health Status?	Signature		Date	Change In Health Status?	Signature
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Continued from front side

14. Medications being taken now - Please list:

Yes No

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

15. Women

- a. Are you taking contraceptives?
- b. Are you pregnant?
- c. Have you had a miscarriage or stillbirth?
- d. Have you had a baby with birth weight more than 10 pounds, or low weight?
- e. Are you nursing presently?

DENTAL INFORMATION

Yes No

- ☐ ☐ 16. Have you ever had an upsetting experience in the dental office?
- ☐ ☐ 17. Is it important for you to keep your teeth?
- ☐ ☐ 18. Are you dissatisfied with the appearance of your teeth?
- ☐ ☐ 19. Are you dissatisfied with the function of your teeth?
- ☐ ☐ 20. Is there anything about having dental treatment that bothers you?
- ☐ ☐ 21. Does food tend to become caught between your teeth?
- ☐ ☐ 22. Do your gums often bleed while brushing?
- ☐ ☐ 23. Have you noticed any loosening of teeth?
- ☐ ☐ 24. Have you had an injury to your head, neck, or jaw?

25. Habits - Do you:

- ☐ ☐ a. Clench your teeth while awake or asleep?
- ☐ ☐ b. Bite your lips or cheek frequently?

26. Problems of the jaw - Have you noticed:

- ☐ ☐ a. clicking of the jaw?
- ☐ ☐ b. Pain (joint, ear, side of face)?
- ☐ ☐ c. Difficulty in opening or closing?
- ☐ ☐ d. Difficulty in chewing?

27. Have you had:

- ☐ ☐ a. Orthodontic treatment (braces)?
- ☐ ☐ b. Oral surgery?
- ☐ ☐ c. Gum treatment?
- ☐ ☐ d. Your bite adjusted?
- ☐ ☐ e. Worn a bite plane or other appliance?
- ☐ ☐ 28. Are you having dental pain at this time?
- ☐ ☐ 29. Has any one in your family had gum treatment?
- ☐ ☐ 30. Do you supplement your diet with fluoride?

31. Date of last dental treatment _____

32. Date of last teeth cleaning _____

Please explain if you answered "YES" to, or are uncertain about, any of the above items.

To the best of my knowledge, the above information is complete and correct.

Signature - Patient (or parent/guardian if patient is under age 18)

Date