

MEDICAL HISTORY

Name: _____
Phone: _____

Physicians name: _____
Phone: _____

Y N Have you been under special care of a medical doctor in the past two years?

Y N Are you currently taking any medications? Please list those below; including the amount and frequency .

Please X the following that apply.

Conditions:

- Abnormal bleeding
- Alcohol or drug dependency
- Allergies
- Angina Pectoris
- Arthritis
- Artificial Heart Valve
- Artificial Joints
- Asthma
- Blood Transfusion
- Chemotherapy
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Emphysema
- Epilepsy
- Fainting Spells
- Fever Blister/Cold Sores
- Glaucoma
- HIV/AIDS
- Heart Attack

- Heart Surgery
- Hemophilia
- Hepatitis
- High Blood Pressure
- Kidney Problems
- Liver Disease
- Mitral Valve Prolapse
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Reflux/GERD
- Rheumatic Fever
- Seizures
- Shingles
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Allergies:

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Jewelry
- Latex
- Metals
- Penicillin
- Tetracycline
- Other: _____

- Use of chewing tobacco
- Smoke cigarettes

How much: _____

If female, please answer the following:

- Oral contraceptives
- Pregnant # of weeks _____
- Nursing
- Hormone Replacement Therapy

DENTAL HISTORY

- Do you have anxiety about dental care?
- Current pain/discomfort in jaw, mouth, etc?
- Have you ever had injury to your face, jaw, or teeth?
- Have you ever had braces?
- Have you had your wisdom teeth extracted?
- Do you wear removable dentures?
- Do you use fluoride toothpaste?
- Do you use fluoride rinses?
- Have you ever taken fluoride supplements?
- Do you drink pop or sports drinks (like Gatorade)?
- Do you drink coffee?
- Do you have well water in your home?

Notes for office use only:

How long has it been since your last dental check-up? _____ months/years (circle)

Any additional information you would like to share?

I prefer a private setting with the doctor to discuss my Medical History form.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date

Signature of patient (parent/guardian)

For future use only

Please let us know at any time if you prefer a private setting to discuss changes with the doctor.

Y N Are there any changes from the previous answers on this health history form? (If yes, please describe)

Date

Signature of patient (parent/guardian)

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Date

Signature of patient (parent/guardian)

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Date

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