DENTAL MEDICAL HISTORY FORM

Please answer all questions. Please print.

Patient Name: _____ Date of birth: _____/_____/_____

LAST FIRST MI Today's Date:_____/_____/_____

Dental Information-

Reason for dental visit today: _____

Date of last dental visit: _____Name of dentist: _____

Do you have any dental fears or anxieties related to previous dental experiences? YES NO

If YES, please explain? _____

Are you currently or have you ever experienced any of the following: □ Tenderness □ Sore areas in mouth

□ Bleeding gums □ Pain in or near ears □ Bad breath □ Sensitivity to hot, cold, or sweets

On a scale of 1 – 10, circle your pain level. No Pain Low 1 2 3 4 5 6 7 8 9 10 High

Have you had any serious trouble associated with any previous dental treatment? YES NO

If YES, please explain: _____

Are you wearing removable dental appliances? YES NO

Medical Information-

ALLERGIES: Are you allergic to or had a reaction to any of the following? If Yes, please list what type of reaction on the line provided (rash, welts, etc.)

Aspirin, Motrin (Ibuprofen)	YES NO _____		Latex	YES NO _____	
Barbiturates; sedatives; or sleeping pills	YES NO _____		Local Anesthetics	YES NO _____	
Codeine or other Narcotic	YES NO _____		Acrylic	YES NO _____	
Iodine	YES NO _____		Metals	YES NO _____	
Penicillin, Keflex (Cephalexin), or other antibiotic (List)			If yes, specify _____		
_____	YES NO		Other (list)_____	YES	NO
Tylenol (Acetaminophen)	YES NO		_____	YES	NO

MEDICATIONS: Please list all medications, including non-prescription medications: (if more space is needed, please ask the Front Desk for an additional form).

Name of medication	Amount/dosage	Frequency (how often)	Prescribed by Dr. name	Reason for medication

Do you smoke? YES NO Do you use chewing tobacco? YES NO

Do you currently or have you ever used controlled substances (drugs) YES NO Are you in good health? YES NO

Has there been any change in your general health within the past year? YES NO

Are you under the care of a physician? YES NO If YES, what is the condition being treated? _____

The name and telephone number of the physician: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? YES NO

If YES, please detail the operation or illness: _____

_____

_____

1. Has a medical doctor ever advised you to take antibiotics before a dental procedure "because of something other than a dental infection?" YES NO
   If yes, please specify _____
2. Are you taking or have you been advised to take prescription medication for bone disease? YES NO
   a. If YES, are you currently or have you ever taken one of the following medications?
      □ Actonel (Risedronate) □ Boniva (Ibandronate) □ Fosamax or Fosamax Plus D (Alendronate)
      □ Skelid (Tiludronate) □ Didronel (Etidronate) □ Other _____
3. Have you ever been administered any of the following drugs intravenously (I.V.) for the treatment of cancer?
   □ Aredia (Pamidronate) □ Zometa or Reclast (Zolendronic Acid) □ Benefos (Clodronate)
4. Do you have any artificial joints? YES NO If Yes, Location _____ Date Placed _____
5. Have you received Chemotherapy or Radiation Therapy for malignancy or other disease? YES NO

Women

6. Are you or could you be pregnant? YES NO If YES, what is your due date? _____
7. Are you nursing? YES NO Are you taking birth control pills or hormone replacement? YES NO

Do you have or have you had any of the following diseases or conditions? Please circle the appropriate answer.

Unexplained fever	Yes	No	Shortness of Breath	Yes	No	Hepatitis B	Yes	No
Unexplained weight loss	Yes	No	Tuberculosis	Yes	No	Hepatitis C	Yes	No
Head Injury	Yes	No	Heart Trouble/Heart Attack	Yes	No	Kidney Disease	Yes	No
Epilepsy/Seizures	Yes	No	Angina/ Coronary Insufficiency	Yes	No	Venereal Disease	Yes	No
Nervous Disorder	Yes	No	High Blood Pressure	Yes	No	AIDS/HIV	Yes	No
Mental Disorder	Yes	No	Chest Pain upon Exertion	Yes	No	Arthritis/Rheumatism	Yes	No
Fainting/Dizzy Spells	Yes	No	Damaged or Artificial Heart Valves	Yes	No	Cancer/Tumors	Yes	No
Stroke	Yes	No	Congenital Heart Disease	Yes	No	Diabetes	Yes	No
Glaucoma	Yes	No	Rheumatic Fever	Yes	No	Hypoglycemia	Yes	No
Sinus Problems	Yes	No	Cardiac Pacemaker	Yes	No	Cortisone Injections	Yes	No
Cold Sores/Fever Blisters	Yes	No	Ulcers	Yes	No	Blood or Bleeding Disorder	Yes	No
Thyroid Disease	Yes	No	Liver Disease	Yes	No	Blood Transfusion	Yes	No
Respiratory Problems	Yes	No	Jaundice	Yes	No	Malignant Hyperthermia	Yes	No
Asthma	Yes	No	Hepatitis A	Yes	No			

Explain any YES answers: _____

_____

_____

Do you have any other medical problems or concerns? YES NO _____

_____

Name of person completing this form: _____ Relationship to patient: _____

I certify to the best of my knowledge, the questions on this form have been answered accurately. I understand that providing false or Incorrect information can be detrimental to my (or patient's) health. I understand it is my responsibility to inform the dental office of any changes in my health or medical history. I will not hold my dentist or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

PRINT NAME SIGNATURE