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 gums 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 /alcoholism
- Arthritis
- Anemia
- Bleeding disorders
- Hay fever
- Ulcers
- Jaundice
- Tumor or malignancy
- Radiation treatment
- Blood transfusion
- Painting
- 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.)

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Dosage in mg.</th>
<th>Number of times taken</th>
<th>When (daily, as needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>i.e. Aleve</td>
<td>275</td>
<td>2x</td>
<td>daily</td>
</tr>
<tr>
<td>i.e. Viagra</td>
<td>50</td>
<td>1x</td>
<td>as needed</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Space 1</th>
<th>Space 2</th>
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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.