

# MEDICAL & DENTAL HEALTH HISTORY

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All information submitted is strictly private and confidential. All information must be received prior to your initial appointment with the doctor. Please ask for assistance if you do not understand, or need clarification of, any part of this form. There are 4 pages that comprise this complete form. Please write on the reverse side of any page if you need to add or clarify any information.

Patient Name: _____			
LAST	FIRST	MIDDLE	(Preferred Name)
Social Security #: _____		Birth Date: _____	
Phone Numbers: Home: _____		Work: _____	
Mobile: _____			
Primary Physician: _____		Phone Number: _____	
Address: _____			
Street			
City		State	Zip Code
Preferred Pharmacy: _____		Phone Number: _____	

## HEALTH HISTORY

	Yes	No	Unsure
1. Do you consider yourself to be in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has there been any change in your general health within the past year? If "Yes", please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently being treated for any medical condition? If "Yes", please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been treated for any medical condition within the past 3 years? If "Yes", please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has it been more than 3 years since your last physical examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. When was your last medical visit? _____			
7. Have you ever had a serious illness, operation, or been hospitalized? If "Yes", please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any allergies? If "Yes", please list them below: a) Medications: _____ a) Latex/rubber products: _____ a) Other (foods, hay fever): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had a peculiar or bad reaction to any medicines or injections? If "Yes", please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HEALTH HISTORY (continued)**

**Yes No Unsure**

10. During the last 6 months, have you taken or are you taking any medications, non-prescription drugs or herbal supplements of any kind? \_\_\_\_\_

Conditions	Drug	Dosage	Frequency Used

11. Are you on a special diet? \_\_\_\_\_

12. Have you lost or gained more than ten pounds during the last year? \_\_\_\_\_

13. Do you use tobacco products? \_\_\_\_\_

If "Yes", please indicate:

- Cigarettes?                      How many per day? \_\_\_\_\_ How many years? \_\_\_\_\_
- Cigars?                                How many per week? \_\_\_\_\_ How many years? \_\_\_\_\_
- Pipe smoking?                      How many per week? \_\_\_\_\_ How many years? \_\_\_\_\_
- Chewing Tobacco                  How often? \_\_\_\_\_ How many years? \_\_\_\_\_

14. Do you have, or have you had any of the following diseases or conditions:

(Circle any that apply)

- |                            |                          |                               |
|----------------------------|--------------------------|-------------------------------|
| a) Cardiovascular disease  | Angina                   | Chest Pain                    |
| Heart Trouble              | Heart Attack             | Coronary Insufficiency        |
| High or Low Blood Pressure | Heart Surgery            | Coronary Occlusion            |
| Heart Murmur               | Irregular Heart Beat     | Coronary Angioplasty          |
| Mitro Value Prolapse       | Stroke                   | Arteriosclerosis              |
| Congenital Heart Defect    | Congestive Heart Failure | Rheumatic Fever/Scarlet Fever |

If "Yes", please describe the disease/condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

b) Shortness of breath? Require extra pillows at night? \_\_\_\_\_

c) Respiratory conditions (asthma, tuberculosis, emphysema, persistent cough)

If "Yes", please describe: \_\_\_\_\_  
 \_\_\_\_\_

e) Abnormal bleeding associated with previous surgery or trauma

f) Blood disorder (Example: anemia or hemophilia) \_\_\_\_\_

g) Bruise easily \_\_\_\_\_

h) Fainting or dizzy spells \_\_\_\_\_

i) Epilepsy, seizures, or convulsions \_\_\_\_\_

j) Diabetes \_\_\_\_\_

k) Hypoglycemia (Low Blood Sugar) \_\_\_\_\_

l) Liver disease; Jaundice; or Hepatitis \_\_\_\_\_

Type of Hepatitis: \_\_\_\_\_

**HEALTH HISTORY (continued)**

	Yes	No	Unsure
m) Kidney or bladder trouble _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Thyroid disorder (Hypothyroid, Hyperthyroid, Goiter, Thyroid removed) __	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Organ transplant _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Arthritis or inflammatory rheumatism (painful swollen joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Joint replacement (i.e.: hip, knee) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", describe which joint and when: _____			
_____			
r) Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", area diagnosed and treatment(s) administered: _____			
_____			
s) Psychiatric conditions _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) Sexually transmitted disease (i.e. Syphilis, Gonorrhea, or Chlamydia) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", describe: _____			
_____			
v) Herpes (Cold Sores) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w) Alcohol, drug or chemical dependency _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x) Trauma or injury to the head or neck _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", describe when and where: _____			
_____			
15. Have you had any X-Rays (dental or medical) taken in the last year? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", describe when / where: _____			
_____			
16. Have you received X-Ray or radioactive isotopes for treatment of disease? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have, or have you had, any other condition not mentioned above? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", please specify: _____			
_____			

**Female Patients Only**

18. Are you pregnant or suspect you may be pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", when is your due date? _____			
19. Are you taking birth control pills? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you taking hormone replacement therapy? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Are you taking Oral or IV-administered Bisphosphonates (Fosamax, Boniva, etc.) ? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DENTAL HISTORY**

22. Have you ever been advised to take antibiotics before any dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you had prolonged bleeding following extractions in the past? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Are there any growths or sore spots in your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Have you ever been diagnosed with periodontal disease, gum disease, pyorrhea? ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you ever have a dry or burning mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HEALTH HISTORY (continued)**

**Yes    No    Unsure**

27. When was your last dental visit? \_\_\_\_\_ What was done? \_\_\_\_\_

28. When was your last dental cleaning or periodontal maintenance? \_\_\_\_\_

29. Have you ever had instructions on caring for your teeth and periodontal tissues? \_\_\_

30. Have you ever been diagnosed with or treated for Periodontal Disease? \_\_\_\_\_

31. Have you ever had a allergic reaction to Local Anesthetic (“freezing”)? \_\_\_\_\_

32. Is any part of your mouth sore due to clenching and/or grinding? \_\_\_\_\_

33. Have you had any difficult extractions in the past? \_\_\_\_\_

34. Do you have difficulty opening your mouth? \_\_\_\_\_

35. Do you have any current dental concerns/problems? \_\_\_\_\_

If “Yes”, please specify: \_\_\_\_\_

**Additional Health History Information / Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please initial each statement, sign and date below.

\_\_\_ I certify that I read, write, and speak English.

\_\_\_ I certify that I have read and fully understand the terms and words within this document, the **MEDICAL & DENTAL HEALTH HISTORY**.

\_\_\_ I have accurately, truthfully and completely answered the questions on this form to the best of my knowledge.

\_\_\_ I understand that it is my responsibility to inform the dental office of changes in my medical status.

\_\_\_ I understand that providing inaccurate or incomplete information may be hazardous to my health.

\_\_\_\_\_  
**Patient’s signature (or Responsible party/Parent/Guardian)**

\_\_\_\_\_  
**Date**



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