



Maria G. Duque, D.D.S. Dental Arts

Patient Medical & Dental History Form

Medical History

Do you consider yourself to be in good health? Yes No Date of last medical exam: _____

Are you currently under medical care? Yes No If yes, for what? _____

Are you currently taking any medication? Yes No If yes, please list: _____

Are you allergic to any medication? Yes No If yes, please list: _____

Do you smoke? Yes No If yes, how long have you smoked? _____

Do you have or have you had:

Heart Trouble / Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
High / Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Major Operation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS or HIV Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis / Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you allergic to:

Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other antibiotic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No

Dental History

Date of last dental exam: _____ Date of last oral x-ray: _____

Are you experiencing dental discomfort? Yes No If yes, please describe: _____

Have you had complications related to a dental procedure (e.g.: extensive bleeding, fainting)? Yes No

If yes, please describe: _____

Are you an anxious dental patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you floss regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use an electric brush?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have bleeding or swollen gums?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you satisfied with the appearance of your teeth and smile? Yes No

If no, what would you like to change? _____

Do you desire straighter teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you desire whiter teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------------------	--	-----------------------------	--

By signing below patient acknowledges that information provided above is to the best of patient's recollection and understanding.

Patient's Signature: _____ **Date:** _____