

MEDICAL-DENTAL HISTORY

Patient's Name _____ DOB _____ SSN _____

INSTRUCTIONS:

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office—to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to your medical condition; in that event you are to write "N/A" (not applicable) in the space provided. All questions must be answered.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." Please sign it in the presence of a member of the office staff.



ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & telephone # of your physician _____

2. Date of last visit to your doctor _____ Purpose of visit _____

3. Do you suffer from any disability? _____ If yes, describe _____

4. Have you ever, or do you now take illegal drugs? _____ Is yes, what drugs, and when taken? _____

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

5. Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____

6. Do you now have, or have you ever had a venereal disease? _____ If yes, describe. _____

7. Have you ever had, or do you now have hepatitis? _____ If yes, describe. _____

8. For females: Are you pregnant? _____ If yes, when are you due? _____

9. For females: Are you taking birth control pills? _____ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

10. Are you taking any drugs or medications? _____ If yes, list and describe amounts and purpose. _____

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

11. Have you ever had an allergic reaction to medication? _____ If yes, describe. _____

12. Have you lost weight recently? _____ If yes, describe. _____

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _____

14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____

15. Stomach or intestinal disease? _____

16. Abnormal blood pressure, excessive bleeding, or anemia? _____

17. Breathing problems, asthma, tuberculosis, or hay fever? _____

18. Cancer, X-ray treatments, or chemotherapy? _____

19. Diabetes? _____
20. Kidney problems or renal dialysis? _____
21. A stroke, convulsions, or fainting spells? _____

22. Tumors or growths? _____

23. Arthritis or rheumatism? _____
24. Have you ever had a major operation? _____ Is yes, describe. _____

25. Have you ever had a serious injury to your head or neck? _____ If yes, describe. _____

26. Are you on a special diet? _____ If yes, for what reason and describe. _____

27. Do you smoke? _____ If yes, describe type and quantity. _____
28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? _____ If yes, describe. _____

29. Are there any other problems about your health of which you are aware? _____

DENTAL HISTORY

Date of your last visit to a dentist _____

Reason for your last visit (or series o visits) _____

Do you have any of your X-rays or dental records? _____

In respect to any previous dental treatment have you:

30. Ever fainted? _____

31. Had an allergic reaction? _____

32. Had abnormal bleeding? _____

33. Any other complications during or following dental treatment? _____ If yes, describe. _____

34. Do your gums bleed on brushing or eating? _____

35. Does food catch between your teeth? _____

