# FAMILY DENTAL MEDICAL HISTORY FORM

Please take sufficient time to **CAREFULLY** and **COMPLETELY** fill out this form. It is very important and can directly affect the treatment that you receive in this office.

| | Yes | No |
|---|---|---|
| 1. Are you now, or have you been under a physician's care during the past 3 years . . . . . . . . . . . | ☐ | ☐ |
| 2. Have you been in the hospital at any time during the past 3 years? . . . . . . . . . . . . . . . . . . . . . . . . . | ☐ | ☐ |
| 3. Do you have allergies or sensitivities to drugs SUCH AS, BUT NOT LIMITED TO Penicillin, Novocain, Codeine, Aspirin, Latex etc? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | ☐ | ☐ |

4. **Please list *ALL* drugs or products to which you are allergic on the line below**

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5. **Please list the names of All medications that you are currently taking.** Please include birth control pills, any "natural herbal medicines" and other "over-the counter" drugs. IF YOU ARE NOT TAKING ANY MEDICATIONS AT THIS TIME, PLEASE WRITE THE WORD "**NONE**" ON THE LINES BELOW.

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| | Yes | No |
|---|---|---|
| 6. Have you ever taken prolonged or high-dose steroid medication in the past 2 years? . . . . . . . . | ☐ | ☐ |
| 7. Are you currently dieting or HAVE YOU EVER taken diet pills? . . . . . . . . . . . . . . . . . . . . . . . | ☐ | ☐ |
| 8. Have you recently been taking "blood-thinners" or aspirin? . . . . . . . . . . . . . . . . . . . . . . . . . . . . | ☐ | ☐ |
| 9. Have you ever had any excessive bleeding requiring special treatment? . . . . . . . . . . . . . . . . . . | ☐ | ☐ |
| 10. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy? . . . . . . . . . . . | ☐ | ☐ |
| 11. Have you ever had breathing difficulties, such as asthma, emphysema or tuberculosis? . . . . . . | ☐ | ☐ |
| 12. Are you, or could you be pregnant? Nursing? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | ☐ | ☐ |
| 13. Do you smoke cigarettes or use tobacco products? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | ☐ | ☐ |
| 14. Is there any present or past history of drug or alcohol abuse? Eating disorder? . . . . . . . . . . . . . | ☐ | ☐ |
| 15. Do you snore or have you ever been diagnosed with sleep apnea? . . . . . . . . . . . . . . . . . . . . . . . . | ☐ | ☐ |
| 16. Has any **physician – M.D. (not dentist)** ever told you to take antibiotics **prior** to <u>every</u> dental appointment? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | ☐ | ☐ |
| 17. Do you have problems with your jaw joint (TMJ)? – clicking, popping, pain, limitation of opening? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | ☐ | ☐ |
| 18. Are there any behavioral / psychiatric / developmental or learning problems / delays? . . . . . . . | ☐ | ☐ |

**Please check yes or no** to any of the following problems that you have or have had in the past.

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Angina (chest pain) . . . . . | ☐ | ☐ | Diabetes. . . . . . . . . | ☐ | ☐ | Anemia . . . . . . . . . . . . . | ☐ | ☐ |
| Rheumatic Fever . . . . . . . | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | | | |
| Any form of cancer . | ☐ | ☐ | Aids / HIV……… .. | ☐ | ☐ | | | |
| Kidney Problem . . . . | ☐ | ☐ | Thyroid Disease……. | ☐ | ☐ | | | |
| Artificial heart valve. . . . | ☐ | ☐ | Glaucoma . . . . . . . . | ☐ | ☐ | **Any medical condition not listed above . . . . . . .** | ☐ | ☐ |
| Heart Attack. . . . . . . . . . | ☐ | ☐ | Ulcers. . . . . . . . . . . . | ☐ | ☐ | | | |
| Irregular heart beat. . . . . | ☐ | ☐ | Shortness of breath . | ☐ | ☐ | | | |
| Pacemaker . . . . . . . . . . . . | ☐ | ☐ | Artificial joint . . . . . | ☐ | ☐ | | | |
| Angioplasty/bypass surgery | ☐ | ☐ | Stroke / TIA. . . . . . . . | ☐ | ☐ | | | |
| Any other heart trouble. . . | ☐ | ☐ | Hepatitis / liver disease | ☐ | ☐ | | | |

**I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction . I will not hold any member of Family Dental legally responsible for any errors or omissions that I may have made in the completion of this medical history form.**

**Signature of Patient/Guardian** ________________________________________________ **Date:** ____________________