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General Dentistry

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General Dentistry

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Medical History Form

Date _____

Name _____ (Last / First / Middle) Home Phone ( ) _____

Address _____ (Number Street) Business Phone ( ) _____

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____ — _____

Date of Birth ___/___/___ (mo / day / yr) Sex M F Height _____ Weight _____ Single _____ Married _____

Name of Spouse _____ Closest Relative _____ Phone ( ) _____

If you are completing this form for another person, what is your relationship to that person? _____

Referred By _____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? Yes No
2. Has there been any change in your general health within the past year? Yes No
3. My last physical exam was on _____
4. Are you now under the care of a physician? Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine? Yes No
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial valves, including heart murmur or rheumatic heart disease Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerois, stroke) Yes No
      1. Do you have chest pain upon exertion? Yes No
      2. Are you ever short of breath after mild exercise or when lying down? Yes No
      3. Do your ankles swell? Yes No
      4. Do you have inborn heart defects? Yes No
      5. Do you have a cardiac pacemaker? Yes No
   c. Allergy Yes No
   d. Sinus trouble Yes No
   e. Asthma or hay fever Yes No
   f. Fainting spells or seizures Yes No
   g. Persistent diarrhea or recent weight loss Yes No
   h. Diabetes Yes No
   i. Hepatitis, jaundice or liver disease Yes No
   j. AIDS or HIV infection Yes No
   k. Thyroid problems Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. Yes No
   m. Arthritis or painful swollen joints Yes No
   n. Stomach ulcer or hyperacidity Yes No
   o. Kidney trouble Yes No
   p. Tuberculosis Yes No
   q. Persistent cough or cough that produces blood Yes No
   r. Persistent swollen glands in neck Yes No
   s. Low blood pressure Yes No
   t. Sexually transmitted disease Yes No
   u. Epilepsy or other neurological disease Yes No
   v. Problems with mental health Yes No
   w. Cancer Yes No
   x. Problems of the immune system Yes No

(over)

9.	Have you had abnormal bleeding	Yes	No
	a. Have you ever required a blood transfusion?	Yes	No
10.	Do you have any blood disorder such as anemia?	Yes	No
11.	Have you ever had any treatment for a tumor or growth?	Yes	No
12.	Are you allergic to or have you had a reaction to:		
	a. Local anesthetics	Yes	No
	b. Penicillin or other antibiotics	Yes	No
	c. Sulfa drugs	Yes	No
	d. Barbituates, sedatives of sleeping pills	Yes	No
	e. Aspirin	Yes	No
	f. Iodine	Yes	No
	g. Codeine or other narcotics	Yes	No
	h. Other _____	Yes	No
13.	Have you or any of your relatives had a bad reaction to intravenous sedatives or general anesthetics .	Yes	No
14.	Have you had any serious trouble associated with previous dental treatment	Yes	No
	If so, explain _____		
	_____		
15.	Do you have any disease, condition, or problem not listed above that you think I should know about?	Yes	No
	If so, explain _____		
	_____		
16.	Are you wearing contact lenses?	Yes	No
17.	Are you wearing removable dental appliances?	Yes	No

WOMEN

18.	Are you pregnant?	Yes	No
19.	Do you have any problems associated with you menstrual period?	Yes	No
20.	Are you nursing?	Yes	No
21.	Are you taking birth control pills?	Yes	No

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM_____ANY PREVIOUS MAJOR DENTAL TREATMENT: ☐ Yes ☐ No WHEN _____

_____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING (INDICATE WITH A ✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long? _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ TMJ problems
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breating
- ☐ Oral habits, i.e. fingernail biting cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Chewing tobacco
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental floss frequency _____
- ☐ Interdental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or ommissions that I may have made in the completion of this form. I also consent to the use of still and/or video photography for educational purposes or verification of treatment.

Signature of Patient _____

Significant findings from questionnaire or oral interview: _____

_____

_____

_____

Dental management considerations: _____

_____

_____

Date _____ Signature of Dentist _____