Medical/Dental History

MEDICAL HISTORY

1) How would you rate your overall health? ☐ GOOD ☐ FAIR ☐ POOR
2) Date of last physical examination: _____
3) Are you currently under the care of a physician? ☐ YES ☐ NO
   If yes, for what condition(s)? _____
4) Physician information: _____
   NAME PHONE NUMBER
   _____
   ADDRESS CITY STATE ZIP
5) Have you had any serious illness, operations, or been hospitalized within the past 5 years? ☐ YES ☐ NO
   If yes, for what reason? _____
6) Have you had any cosmetic procedures or elective surgeries completed? ☐ YES ☐ NO
   If yes, please describe: _____
   Please provide us with the following information of the physician in charge of the procedure:
   _____
   NAME PHONE NUMBER ADDRESS CITY STATE ZIP
7) Have you had medical x-rays in the last 5 years? ☐ YES ☐ NO
   If yes, please explain: _____
8) Are you taking any prescribed medications, over-the-counter medications, creams, supplements or herbs? If yes, **please list all** ☐ YES ☐ NO

	NAME	DOSE/FREQUENCY	REASON FOR TAKING
PRESCRIBED MEDICATIONS			
OVER THE COUNTER MEDICATIONS			
VITAMINS, NATURAL OR HERBAL PREPARATIONS, DIET SUPPLEMENTS			

9) Do you use tobacco products? ☐ YES ☐ NO
   If yes, how interested are you in quitting? ❑ VERY ❑ SOMEWHAT ❑ NOT INTERSTED
10) Do you drink alcoholic beverages? ☐ YES ☐ NO
    If yes, please list how many per week, e.g., 1-2 drinks/week: _____
11) Do you use recreational or street drugs? ☐ YES ☐ NO
    If yes, how often? _____
12) Do you have any **allergies** (i.e., itching, rash, swelling of hands, eyes, or feet), or are you made sick by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications? ☐ YES ☐ NO
    If yes, please list what you are allergic to and your reaction: _____
    _____
13) When you walk up stairs or take a walk, do you ever have to stop because of chest pain? ☐ YES ☐ NO
14) Do your ankles swell during the day? ☐ YES ☐ NO
15) Do you use more than 2 pillows to sleep? ☐ YES ☐ NO

Patient's Name: _____

16) Do you wake up short of breath? ☐ YES ☐ NO
17) Have you lost or gained more than 10 pounds in the last year? ☐ YES ☐ NO
18) Are you on a special diet? ☐ YES ☐ NO
19) Have you been told that you needed to be premedicated prior to any dental work? ☐ YES ☐ NO
If yes, for what reason? _____

Check any of the following **cardiovascular/heart conditions** you currently have or have had in the past:

☐ Angina ☐ Arteriosclerosis ☐ Artificial heart valves
☐ Chest pain upon exertion ☐ Congenital heart lesions/defects ☐ Congenital heart failure
☐ Coronary artery disease ☐ Damaged heart valves ☐ Heart attack
☐ Heart murmur ☐ Heart surgery ☐ High blood pressure
☐ Irregular heartbeat ☐ Low blood pressure ☐ Mitral valve prolapse
☐ Heart pacemaker ☐ Rheumatic heart disease/Rheumatic fever ☐ Scarlet fever
☐ Stroke ☐ Other (please specify): _____
☐ NONE

Check any of the following **respiratory conditions** you currently have or have had in the past:

☐ Asthma ☐ Bronchitis ☐ Emphysema
☐ Hay Fever ☐ Persistent cough or cough that produces blood ☐ Shortness of breath
☐ Sinus problems ☐ Tuberculosis (TB) ☐ Other (please specify): _____
☐ NONE

Check any of the following **blood disorders** you currently have or have had in the past:

☐ Abnormal bleeding ☐ Anemia ☐ Blood transfusion ☐ Bruise easily
☐ Hemophilia ☐ Excessive bleeding ☐ Leukemia
☐ Sickle cell disease ☐ Other (please specify): _____
☐ NONE

Check any of the following **psychological conditions** you currently have or have had in the past:

☐ Anxiety ☐ Depression ☐ Psychiatric treatment ☐ Nervousness
☐ Other (please specify): _____
☐ NONE

Check any of the following **liver conditions** you currently have or have had in the past:

☐ Cirrhosis/liver disease ☐ Hepatitis ☐ Jaundice/yellow jaundice ☐ Other (please specify): _____
☐ NONE

Check any of the following health conditions you currently have or have had in the past:

☐ Allergies or hives ☐ Arthritis ☐ Artificial Joint ☐ Cancer
☐ Chemotherapy ☐ Cold sores/fever blisters ☐ Cortisone medication ☐ Drug addiction
☐ Epilepsy or seizures ☐ Diabetes ☐ Fainting or dizzy spells ☐ Glaucoma
☐ Herpes ☐ HIV antibody or AIDS ☐ Irritable bowel ☐ Kidney disease/dialysis
☐ Measles ☐ Mumps ☐ Radiation treatment ☐ Rheumatism
☐ Tumor ☐ Sexually transmitted disease ☐ Stomach problems ☐ Thyroid disease
☐ Ulcers
☐ NONE

For women.

1) Are you pregnant? ☐ YES ☐ NO
2) Are you looking to become pregnant? ☐ YES ☐ NO
3) Are you nursing? ☐ YES ☐ NO

Please read and initial:
I understand it is my responsibility to inform the office if I am pregnant, looking to become pregnant, or nursing since it will affect my dental care and the scheduling of appointments. _____

4) Are you using a contraceptive? ☐ YES ☐ NO
If yes, please read and initial.
I understand that taking antibiotics may render contraceptives ineffective. _____

Do you have any disease, condition, or problem that was not previously listed? ☐ YES ☐ NO
If yes, please describe here: _____

Patient's Name: _____