Medical and Dental Health History

Patient Name: ..... Today Date: ..... Social Security: .....

Birthdate: ..... City: ..... State: .....

Zip: ..... Home Number: ..... Cell Phone: .....

E-mail Address: ..... Refer By: ..... Marital Status: .....

Occupation: ..... Employer Name: ..... Employer Number: .....

Emergency Contact: ..... Phone Number: ..... Address: .....

Health History

Do you have, or have you ever had, any of the following conditions:

Food/Drug Allergies: ☐ Yes ☐ No

Heart Condition: ☐ Yes ☐ No

Genital Herpes: ☐ Yes ☐ No

Anemia: ☐ Yes ☐ No

Scarlet Fever: ☐ Yes ☐ No

Kidney Disease: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No

Cold Sores: ☐ Yes ☐ No

Liver Disease ☐ Yes ☐ No

Artificial Joints/Valves: ☐ Yes ☐ No

Bruise Easily: ☐ Yes ☐ No

Psychiatric Problems: ☐ Yes ☐ No

Bleeding Problems: ☐ Yes ☐ No

Alzheimer Disease: ☐ Yes ☐ No

Rheumatic Fever: ☐ Yes ☐ No

Cancer/Chemotherapy: ☐ Yes ☐ No

Frequent cough: ☐ Yes ☐ No

Seizures: ☐ Yes ☐ No

X-ray treatment: ☐ Yes ☐ No

Drug addiction/Alcoholism: ☐ Yes ☐ No

Sickle Cell Anemia: ☐ Yes ☐ No

Cleft Lip & Palate: ☐ Yes ☐ No

High/Low Blood Pressure: ☐ Yes ☐ No

Hives or Rash: ☐ Yes ☐ No

Delay Speech Development: ☐ Yes ☐ No

Infectious Disease: ☐ Yes ☐ No

Jaundice: ☐ Yes ☐ No

Difficulty Breathing: ☐ Yes ☐ No

Herpes: ☐ Yes ☐ No

Ulcers: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

HIV Positive: ☐ Yes ☐ No

Hepatitis: ☐ Yes ☐ No

Emotional Disturbances: ☐ Yes ☐ No

AIDS: ☐ Yes ☐ No

Need Premedication: ☐ Yes ☐ No

Fainting Spells: ☐ Yes ☐ No

Tuberculosis: ☐ Yes ☐ No

Pregnant / Nursing: ☐ Yes ☐ No

Hearing Loss/Impairment: ☐ Yes ☐ No

Patient Initial: ..... Patient Name: ..... Date: .....

Medical and Dental History

Why are you here today ? .....

Do you have a specific dental problem: ☐ Yes ☐ No

Do you smoke or chew tobacco? ☐ Yes ☐ No

When was your last dental examination on a routine basis? ☐ Yes ☐ No

Any Sores or growths in your mouth? ☐ Yes ☐ No

Do you think you have active decay or gum disease? ☐ Yes ☐ No

Name of previous dentist (optional) ☐ Yes ☐ No

Do you brush and floss on a routine basis? ☐ Yes ☐ No

Are you under a physician's care now? Why? ☐ Yes ☐ No

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Do your gums ever bleed? ☐ Yes ☐ No

Have your ever been hospitalized or had major surgery? ☐ Yes ☐ No

Do you have bad breath? ☐ Yes ☐ No

Have you ever had a serious injury to your head or neck? ☐ Yes ☐ No

Do you like your smile? why? ☐ Yes ☐ No

Are you taking any medications now, If so what are you taking? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

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Are you allergic to any medication or substance, if so what? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

Do you have clicking, popping or discomfort in the jaw joint? ☐ Yes ☐ No

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Do you brux or grind? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my dental status. I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment with my informed consent.

Patient Signature: ..... Date: .....

Parent or Guardian: ..... Date: .....

Reviewed by Doctor: ..... Date: .....