MEDICAL DENTAL HISTORY FORM

PATIENT INFORMATION:

Name:______________________________ Birthdate:____________________

Are you currently being treated by a physician?(circle): **Yes** or **No**

Physician's Name, Address, and Phone:______________________________________

Do you need to take antibiotic premedication prior to dental appointments?(circle): **Yes** or **No**

MEDICAL HISTORY:

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for (circle):

Condition			Condition		
Heart murmur	YES	NO	Diabetes	YES	NO
Mitral valve prolapse	YES	NO	Thyroid problems	YES	NO
Heart surgery	YES	NO	Adrenal/Pituitary problems	YES	NO
Artificial heart valves	YES	NO	Liver problems/dysfunction	YES	NO
Heart disease	YES	NO	Hepatitis/jaundice	YES	NO
Pacemaker	YES	NO	Kidney problems/dysfunction	YES	NO
Heart attack	YES	NO	Stomach trouble/ulcers	YES	NO
Stroke	YES	NO	Nervous or mental disorder	YES	NO
Angina	YES	NO	Depression	YES	NO
Bypass	YES	NO	Epilepsy or seizures	YES	NO
Rheumatic Fever	YES	NO	Alcoholism	YES	NO
Artificial joint (hip/knee)	YES	NO	Drug abuse	YES	NO
High blood pressure	YES	NO	Cerebral palsy	YES	NO
Low blood pressure	YES	NO	Lupus	YES	NO
Any bleeding disorders	YES	NO	Arthritis	YES	NO
Anemia	YES	NO	Sjogrens Disease	YES	NO
Hemophilia	YES	NO	Fibromyalgia	YES	NO
Sickle cell trait	YES	NO	Glaucoma	YES	NO
Leukemia	YES	NO	Cancer/tumor	YES	NO
Do you smoke	YES	NO	Chemotherapy/Radiation	YES	NO
Lung/breathing problems	YES	NO	Sexually transmitted diseases	YES	NO
Asthma	YES	NO	HIV/AIDS	YES	NO
Bronchitis	YES	NO	Other infectious diseases	YES	NO
Emphysema	YES	NO	Are you pregnant? (women)	YES	NO
Tuberculosis	YES	NO	Are you nursing? (women)	YES	NO
Sinus Trouble	YES	NO			
Difficulty in healing	YES	NO			

Allergies to (circle):

Penicillin	YES	NO
Erythromycin	YES	NO
Sulfa	YES	NO
Codeine	YES	NO
Aspirin	YES	NO
Latex	YES	NO
Local anesthetic	YES	NO

Are you presently taking any medication or pills? YES NO

List:____________________for____________________

____________________for____________________

____________________for____________________

____________________for____________________

____________________for____________________

Is there any condition relating to your medical history that has not been mentioned? YES NO
Explain:____

DENTAL HISTORY:

Do your gums bleed easily when brushing or flossing?	YES	NO
Do you suffer from chronic bad breath?	YES	NO
Do you have jaw joint cracking or pain?	YES	NO

What was the purpose of your last dental visit?______________________________
When was the last time you had a dental cleaning?______________________________
How often do you brush?______________________________
How often do you floss?______________________________

I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications.

Date__________Patient/Guardian Signature____________________Dr./Hygienist Signature____________________

YEARLY REVIEW OF PATIENT MEDICAL HISTORY

Changes?	List	Date	Parent/Guardian Signature	Doctor/Hygienist Signature