Medical and Dental Health History Form

Patient name (first and last): ______________________________

Name of previous dentist/location: ______________________________

Date of last dental examination and date of last cleaning: ______________________________

Why have you come to see us today (e.g. pain, checkup, etc.)? ______________________________

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Name and contact information of family physician: ______________________________

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Dental Health:

Yes	No	
☐	☐	Do you brush your teeth? How often? ______________________________
☐	☐	Do you floss? How often? ______________________________
☐	☐	Are you having any pain or discomfort at this time?
☐	☐	Do your gums bleed while brushing and flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Have you ever experienced any of the following problems with your jaw?

(Circle all that apply): clicking pain difficulty in opening and closing difficulty in chewing

Yes	No	
☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth? If yes, when? ______________________________
☐	☐	Have you ever had any orthodontic treatment? If so, do you wear a retainer? ______________________________
☐	☐	Have you ever had facial surgery? If so, when and what area of your face? ______________________________
☐	☐	Have you ever had any type of trauma to your mouth, jaw or face? If yes, describe: ______________________________
☐	☐	Do you wear dentures or partials? If so, date of placement: ______________________________
☐	☐	Do you have any concerns about bad breath odor?
☐	☐	Are you pleased with the appearance/color of your teeth when you smile?
☐	☐	Is there any dental treatment you are not happy with?
☐	☐	Are you nervous about dental treatment?

Medical Health:

Are you allergic or have you reacted adversely to any of the following (check all that apply):

___ Aspirin
___ Codeine
___ Nitrous Oxide
___ Penicillin
___ Erythromycin
___ Other antibiotics ____________________
___ Latex, Metals, Plastic

__ Ibuprofen
__ Sulfa Drugs, Sulfites, Sulfides
__ Acetaminophen/Tylenol
__ Barbiturates
__ Tetracycline
__ Local Anesthesia (Novocain)

Please list any other allergies to include medications you are allergic to:

Check any of the following that you have had or have at the present:

___ Osteoporosis
___ Heart disease or heart attack
___ Abnormal blood pressure
___ Heart murmur/mitral valve prolapse
___ Rheumatic fever
___ Heart pacemaker
___ Heart surgery
___ Stroke
___ Kidney disease
___ History of drug addiction /alcoholism
___ Arthritis
___ Anemia
___ Bleeding disorders
___ Hay fever
___ Ulcers
___ Jaundice
___ Herpes
___ Tumor or malignancy
___ Radiation treatment
___ Blood transfusion
___ Fainting
___ Headaches
___ Glaucoma
___ Shingles

__ Bisphosphonate therapy (e.g. Boniva)
__ Asthma
__ Diabetes
__ Thyroid issues
__ Hepatitis A, B, C
__ Hemophilia
__ Epilepsy or seizures
__ Psychiatric treatment
__ Artificial joints
__ Anemia
__ AIDS or HIV+
__ Congenital heart lesions
__ Tuberculosis or lung disease
__ Sinus issues
__ Liver disease
__ Infectious mononucleosis (mono)
__ Sexually transmitted/venereal disease
__ Cancer/chemotherapy/radiation
__ Implants/artificial joints
__ Anaphylaxis
__ Allergies (including food)
__ Hard of hearing
__ Sickle cell disease/traits

Other: ____

Major surgeries (type and year): ____

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Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements. (If you have a medication list please provide us with it)

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Yes	No	
☐	☐	Have you been hospitalized during the past two years?
☐	☐	Have you been asked by your medical doctor to premedicate before any dental treatment?
☐	☐	Have you taken Fen-Phen, Redux or appetite suppressants? If yes, have you seen a Physician for a cardiac evaluation?
☐	☐	Do you have any disease, condition or problem not listed?
☐	☐	Do you smoke or use chewing tobacco?
☐	☐	Do you smoke or ingest marijuana or use illegal drugs?
☐	☐	Do you drink alcohol? If yes, how often and in what quantity?
☐	☐	Do you take erectile dysfunction medication?

For Women Only:

Yes	No	
☐	☐	Are you/could you be pregnant? If yes, due date: ____________________
☐	☐	Are you taking birth control pills?
☐	☐	Are you nursing?
☐	☐	Are you on hormone replacement therapy?