Dental and Medical History Form

NAME: _____ **DOB:** _____

1) THE MAIN REASON FOR MY DENTAL APPOINTMENT IS: _____

_____

_____

2) ARE YOU IN DENTAL PAIN? ☐ YES ☐ NO

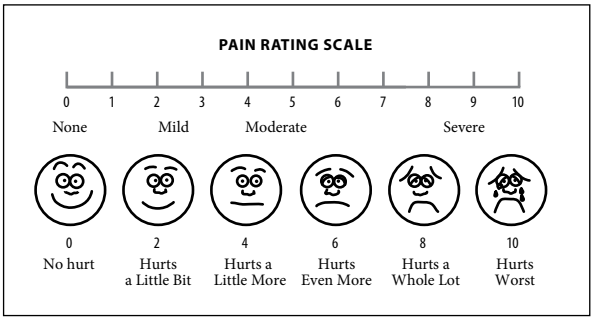
IF YES, ON THE PAIN SCHEDULE TO THE RIGHT PLEASE CIRCLE HOW MUCH PAIN YOU ARE IN:

WHERE IS THE PAIN?

☐ UPPER RIGHT ☐ UPPER FRONT ☐ UPPER LEFT

☐ LOWER RIGHT ☐ LOWER FRONT ☐ LOWER LEFT

DESCRIBE THE PAIN: ☐ THROBBING, ☐ SHARP, ☐ CONSISTENT, ☐ INTERMITTENT, ☐ DULL



3) DATE OF LAST DENTAL EXAMINATION (MM/YY) _____

4) HOW SATISFIED HAVE YOU BEEN WITH YOUR PREVIOUS DENTAL CARE? 1 2 3 4 5

NOT SATISFIED VERY SATISFIED

5) DO YOU FEAR RECEIVING DENTAL CARE? ☐ YES ☐ NO ☐ UNSURE

THE FOLLOWING INFORMATION IS ESSENTIAL FOR THE SAFE AND EFFECTIVE DIAGNOSIS AND TREATMENT OF EACH PATIENT.
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

6) CONGENITAL HEART DISEASE/ HEART MURMUR/RHEUMATIC FEVER ..... Y N
7) HEART ATTACK ..... Y N
8) IRREGULAR HEART BEAT ..... Y N
9) ANGINA/CHEST PAIN ..... Y N
10) HEART SURGERY ..... Y N
11) ARTIFICIAL HEART VALVE ..... Y N
12) HEART PACE MAKER ..... Y N
13) HIGH BLOOD PRESSURE ..... Y N
14) LOW BLOOD PRESSURE ..... Y N
15) STROKE/PARALYSIS ..... Y N

RESPIRATORY
16) ASTHMA ..... Y N
17) BREATHING PROBLEM (SLEEP APNEA, EMPHYSEMA, SHORTNESS OF BREATH, OXYGEN DEPENDENT, COUGH) ..... Y N
18) TUBERCULOSIS ..... Y N

GASTRO-INTESTINAL
19) KIDNEY DISEASE ..... Y N
20) LIVER DISEASE/YELLOW JAUNDICE ..... Y N
21) STOMACH/INTESTINAL DISEASE/ULCERS REFLUX ..... Y N

NEUROLOGY
22) CONVULSIONS/SEIZURES/EPILEPSY ..... Y N
23) NUMBNESS OR TINGLING/BACKPAIN ..... Y N
24) PSYCHIATRIC TREATMENT ..... Y N
25) FAINTING/DIZZINESS ..... Y N

ENDOCRINE
26) DIABETES TYPE 1 TYPE 2 ..... Y N
27) STEROID TREATMENT (CORTISONE) ..... Y N
28) THYROID PROBLEM ..... Y N

HEMATOLOGY
29) BLEEDING/BRUISING EASILY/ BLOOD DISORDER ..... Y N
30) IMMUNE SYSTEM (LUPUS, IMMUNODEFICIENCY, SJOGRENS) ..... Y N

INFECTIOUS DISEASE
31) HIV/AIDS ..... Y N
32) HERPES ..... Y N
33) HEPATITIS A, B or C ..... Y N

MUSCULOSKELETAL
34) RHEUMATISM/ARTHRITIS/PAIN IN JOINTS ..... Y N
35) ARTIFICIAL JOINT ..... Y N
36) OSTEOPOROSIS/BISPHOSPHONATE THERAPY ..... Y N

GENERAL
37) CURRENT CANCER ..... Y N
38) PAST CANCER ..... Y N
39) RADIATION THERAPY ..... Y N
40) CHEMOTHERAPY ..... Y N
41) RECENT WEIGHT GAIN/LOSS ..... Y N
42) FEN-PHEN USE ..... Y N
43) DRUG/ALCOHOL TREATMENT ..... Y N
44) HIVES/RASH ..... Y N
45) DIFFICULTY HEARING ..... Y N
46) EYE PROBLEMS (DRY EYES/GLAUCOMA) ..... Y N
47) WOMEN ONLY: ARE YOU OR COULD YOU BE PREGNANT? ..... Y N

48) DO YOU HAVE ANY OTHER MEDICAL CONDITIONS NOT LISTED? _____

49) HAVE YOU EXPERIENCED AN UNUSUAL OR ALLERGIC REACTION TO ANY OF THE FOLLOWING?

☐ LOCAL ANESTHETIC ☐ CODEINE ☐ ASPIRIN
☐ PENICILLIN ☐ NARCOTICS ☐ METALS
☐ SULFA DRUGS ☐ LATEX RUBBER ☐ OTHERS _____

50) HAVE YOU BEEN HOSPITALIZED IN THE PAST YEAR? ☐ YES ☐ NO

IF YES, WHAT WERE YOU TREATED FOR? _____

51) PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING:
(INCLUDING OVER THE COUNTER, SUPPLEMENTS, OR HERBALS)

NAME	DOSAGE	ROUTE OF INTAKE	MEDICAL CONDITION

52) TOBACCO USE

CIGARETTES
☐ QUIT: DATE _____
☐ NEVER
☐ CURRENT SMOKER: PACKS/DAY_____ # OF YRS _____

OTHER TOBACCO: ☐ PIPE ☐ CIGAR ☐ SNUFF ☐ CHEW ☐ BETEL QUID

ARE YOU INTERESTED IN QUITTING? ☐ YES ☐ NO

53) ALCOHOL USE

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO # DRINKS/WEEK_____

54) DRUG USE

DO YOU USE ANY RECREATIONAL DRUGS? ☐ YES ☐ NO
HAVE YOU EVER USED NEEDLES? ☐ YES ☐ NO

55) DO YOU FEEL SAFE AT HOME? ☐ YES ☐ NO

56) DO YOU HAVE ACCESS TO MEDICAL CARE?

NAME OF FACILITY:_____

DOCTORS NAME: _____ PHONE:_____

57) HAVE YOU HAD A SCREENING FOR THE FOLLOWING?

COLON CANCER (IF ABOVE 50 YR OF AGE) ☐ YES ☐ NO
BREAST CANCER (IF ABOVE 40 YR OF AGE) ☐ YES ☐ NO
BLOOD PRESSURE ☐ YES ☐ NO
CHOLESTEROL/LIPIDS (IF ABOVE 35 YR OF AGE) ☐ YES ☐ NO
IMMUNIZATIONS (FLU SHOTS, PNEUMONIA) ☐ YES ☐ NO

58) WEIGHT_____ **HEIGHT**_____

I CERTIFY THAT ALL THE INFORMATION I HAVE PROVIDED IS TRUE TO MY KNOWLEDGE.