



Medical and Dental Health History Form Getting to Know You as Our Patient

Patient name (first and last): _____

Name of previous dentist/location: _____

Date of last dental examination: _____ Date of last cleaning: _____

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

Next of Kin Name and Phone Number: _____

Name and contact information of physician: _____

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

- 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 of your teeth when you smile?
- Are you pleased with the colour of your teeth?
- 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):

- | | |
|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulphur Drugs |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Acetaminophen/Tylenol |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Other antibiotics _____ | <input type="checkbox"/> Local Anesthesia |
| <input type="checkbox"/> Latex, Metals, Plastic | |

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:

- | | |
|--|--|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bisphosphonate therapy (e.g. Actonel) |
| <input type="checkbox"/> Heart disease or heart attack | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Abnormal blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart murmur/mitral valve prolapse | <input type="checkbox"/> Thyroid issues |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Artificial joints |
| <input type="checkbox"/> History of drug addiction /alcoholism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS or HIV+ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital heart lesions |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Tuberculosis or lung disease |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sinus issues |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Infectious mononucleosis (mono) |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Sexually transmitted/venereal disease |
| <input type="checkbox"/> Tumor or malignancy | <input type="checkbox"/> Cancer/chemotherapy/radiation |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Implants/artificial joints |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergies (including food) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hard of hearing |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sickle cell disease/traits |
| <input type="checkbox"/> Shingles | |

Other: _____

Major surgeries (type and year): _____



List sports activities: _____

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements. (Two examples are listed below.)

Name of medication	Dosage in mg.	Number of times taken	When (daily, as needed)
e.g. Aleve	275	2x	daily

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been hospitalized during the past two years? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been asked by your medical doctor to premedicate before any dental treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you taken Fen-Phen, Redux or appetite suppressants? If yes, have you seen a physician for a cardiac evaluation? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any disease, condition or problem not listed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke or use chewing tobacco? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke or ingest marijuana? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol? If yes, how often and in what quantity? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take Viagra? |

For Women Only:		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If yes, due date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking birth control pills?
<input type="checkbox"/>	<input type="checkbox"/>	Could you be pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?
<input type="checkbox"/>	<input type="checkbox"/>	Are you undergoing fertility therapy?
<input type="checkbox"/>	<input type="checkbox"/>	Hormone replacement?



This form is designed to solicit information typically required to plan treatment. The space below is for you to tell me other information you believe I should take into account when planning your treatment.

If you have any questions about this form or are unsure how to answer any questions, we'd be happy to assist you, please ask!

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signed: _____ Date: _____

Patient Review and Update of Form: At each visit please review this form, note any changes, sign and date in the spaces below:
