Medical History

Name: _____Date of Birth: _____ Contact Number: _____

Address: _____

Emergency Contact: _____ Relationship: _____ Contact Number: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Yes No Are you under a physician's care?
If yes, why. _____
Physician's Name: _____ Phone Number: _____
Yes No Are you currently taking any medications?
If yes, please list them. _____
Yes No Have you ever been hospitalized or had a major operation? _____
Yes No Have you ever had a serious neck or head injury? _____
Yes No Do you use tobacco? If yes, please circle: cigarettes pipe e-cig chewing-tobacco cigar
Yes No Do you use a controlled substance? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/ Hemophilia	Cancer	Gastrointestinal Disorder	Psychiatric Care
Alzheimer's Disease	Cold Sores	Heart Murmur	Pneumonia
Anemia	Congenital Heart Defect	Heart Problems	Prolonged bleeding
Arthritis	Diabetes	Hepatitis	Radiation/ Chemotherapy
Artificial Joint	Dizziness/ Fainting Spells	Herpes	Rheumatic Fever
Asthma/ Breathing Problems	Drug Addiction	High Blood Pressure	Stroke
Blood Disease	Epilepsy/ Seizures	HIV/AIDS Kidney Problems	Tuberculosis
Bone Disorders	Frequent Headaches	Kidney Problems	Tumor or Cancer

Women: Are you….

Pregnant/ Trying to get pregnant Nursing Taking Oral Contraceptives

Are you allergic to any of the following?

Acrylic Aspirin Codeine Latex Local Anesthetics Metal Penicillin Sulfa

Dental History

Yes No Are you having any dental concerns? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw popping or clicking? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Do your gums bleed when you brush? _____
Yes No Have you ever been seen by an orthodontist? If yes, who and when? _____
Yes No Do you frequently breath through your mouth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do you have any type of thumb or tongue habit? _____

Is there anything you would like to change about your smile? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____