# DENTAL PATIENT MEDICAL HISTORY

| Name (Last, First, M.I.) | Social Security # | | Date of Birth |
|---|---|---|---|
| Address | Home Phone # | Work Phone # | Cell Phone # |
| City State Zip | Email Address | | |
| Employer Name Address City State Zip | | | Marital Status S M W D |

**The answers to the following questions will assist the dentist in evaluating your general health prior to providing your dental treatment. PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE.**

1. WHAT IS YOUR IMPRESSION OF YOUR PRESENT HEALTH?

2. YEAR LAST MEDICAL PHYSICAL?

3. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT.

| | | | | |
|---|---|---|---|---|
| Heart Disease | Rheumatic Fever | Asthma | Hepatitis | Venereal Disease (Syphilis, Gonorrhea) |
| Angina Pectoris | Stroke | Hay Fever | Thyroid Disease | Drug Addiction |
| Frequent Chest Pains | Hemophilia | Emphysema | Glaucoma | Psychiatric Treatment |
| High Blood Pressure | Bruise Easily | Tuberculosis (TB) | Epilepsy or Seizures | Cancer |
| Shortness of Breath | Prolonged or Unusual Bleeding | Diabetes | Fainting or Dizzy Spells | Radiation Therapy |
| Swollen Ankles | Anemia | Ulcers | AIDS or AIDS Related Complex | Chemotherapy |
| Artificial Heart Valve | Blood Transfusion | Kidney Trouble | HIV Positive | Implant Prosthesis |
| Congenital Heart Disease | Sickle Cell Disease | Liver Disease | Cold Sores | Unexplained Weight Loss |
| Heart Murmur | Arthritis | Jaundice (Other than at birth) | Genital Herpes | |

**CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS.** *(IF IN DOUBT, CIRCLE YES)*
*(IF YES, please give details.)* **CONTINUE COMMENTS ON BACK IF NECESSARY.**

| | | |
|---|---|---|
| 4. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR? | YES | NO |
| 5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS? | YES | NO |
| 6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS? | YES | NO |
| 7. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC? | YES | NO |
| 8. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT? | YES | NO |
| 9. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE? | YES | NO |
| 10. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR? | YES | NO |
| 11. DO YOU USE TOBACCO? (If YES, please circle and give frequency) **SMOKE:** Cigarettes Cigars Pipe **SMOKELESS:** Chewing Tobacco Snuff or "Dip" **FREQUENCY:** | YES | NO |
| 12. HAVE YOU USED COCAINE IN THE LAST 24 HOURS? | YES | NO |
| 13. HAVE YOU USED METH AMPHETAMINE IN THE LAST 24 HOURS? | YES | NO |

14. **WOMAN:** ARE YOU PREGNANT? *(If YES, please circle trimester block)* YES NO — 1 2 3

15. WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

| **PATIENT COMMENTS** *(Check this box if you have added comments on the back of this form)* ☐ | **SIGNATURE OF PATIENT** *(or legal guardian if patient is a minor)* × | **DATE** |
|---|---|---|

**DENTIST'S COMMENTS**

| BLOOD PRESSURE | DATE | BLOOD PRESSURE | DATE | BLOOD PRESSURE | DATE | BLOOD PRESSURE | DATE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| DENTIST'S SIGNATURE | DATE | REVIEWER | DATE | REVIEWER | DATE | REVIEWER | DATE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

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