[patient.nextapptprovider], [patient.nextapptdate], [patient.nextappttime]

MEDICAL DENTAL HISTORY FORM

Patient Name:
Patient ID #:

Medical Clinic _____

Physician _____

Allergies to:
Latex: Yes No
Medications _____
Other _____

PreMed required? Yes No

Reason: _____

Type: _____ Dosage: _____

Current Medications (Prescription, Over the counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PAST AND CURRENT MEDICAL CONDITIONS (mark all that apply)

	Yes
8 Under physician's care?	
Details:	
9 Hospitalization/operation(s) in last 5 years?	
Details:	
10 Head/neck/mouth injuries?	
11 Women: pregnant?	
12 Women: nursing?	
13 Women: oral contraceptives?	
14 Heart trouble/disease?	
15 Rheumatic fever?	
16 Past use of Fenphen?	
17 Heart murmur?	
18 Mitral valve prolapse?	
19 Heart surgery?	
20 Artificial heart valves?	
21 Pacemaker?	
22 Indwelling defibrillator?	
23 Artificial joints?	
24 History of Organ Transplant?	
25 High blood pressure? BP: /	
26 Stroke?	
27 Bleeding problem?	
28 Hemophilia?	
29 Anemia?	
30 Leukemia?	
31 Lung disease?	
32 Emphysema?	
33 Shortness of Breath?	

	Yes
34 Asthma?	
35 Sleep Apnea?	
36 Tuberculosis?	
37 Sinus trouble?	
38 Cancer?	
39 Radiation Treatment to Head/Neck?	
40 Chemotherapy?	
41 Kidney Disease?	
42 Dialysis?	
43 Eating Disorder?	
44 Stomach: reflux? ulcer?	
45 Immunological disease?	
46 Sjogrens Disease?	
47 Fibromylagia?	
48 Other autoimmune disease (lupus, pemphilus)?	
49 Arthritis or other joint disorders?	
50 Diabetes? Type: Controlled? Y N	
51 Headaches?	
52 Depression: Diagnosed?	
53 Other Psychiatric Disorders?	
54 Neurologic Disease?	
55 Convulsions?	
56 Epilepsy/seizures?	
57 Cerebral Palsy?	
58 Fainting/dizziness?	
59 Venereal disease?	
60 AIDS/HIV positive?	
61 Alcohol or chemical dependency?	
62 Hepatitis?	
63 Thyroid disease?	
64 Glaucoma?	

TOBACCO

	Yes
65 Tobacco user?	
Type:	
Amount:	
Number of years:	
66 How soon after wake up do you use tobacco? <30 minutes >30 minutes	
67 Previous attempts to quit?	
Number of attempts:	
Longer period of success:	
Methods used:	
68 Are you interested in quitting tobacco?	
69 Former tobacco user?	
Type:	
Amount:	
Year quit:	

DENTAL INFORMATION:

70 Previous dentist:
71 Last dental visit:
72 Last dental cleaning:
73 Frequency of dental exams:
74 What made you decide to make this dentist appointment?
75 Frequency of brushing:
76 Frequency of flossing:
77 What are some typical foods you eat between meals?
78 What types of beverages do you typically drink between meals?
79 How often do you chew or suck on hard candy, cough drops or mints?
80 Do you use fluoridated toothpaste? Yes
81 Primary source of drinking water? (circle) City water filtered City water unfiltered Bottled water Well water

PAST DENTAL TREATMENT:

	Yes
82 One or more fillings in the last three years?	
83 Family history of extensive decay?	
84 If Child, mother's history of decay?	
85 Treatment for periodontal (gum) disease?	
86 Family history of periodontal disease?	
87 Have you had orthodontics (braces)?	
88 Have you had oral surgery?	
89 Have you had any dental implants placed?	
90 Treatment for tempormandibular disorders?	
91 Do you wear a denture(s) or partial denture(s)?	

DO YOU HAVE CONSISTENT PROBLEMS WITH:

92 Dry mouth/excessive thirst?	
93 Sensitive teeth? Hot Cold Pressure Sweets	
94 Mouth odors/bad taste?	
95 Cold sores/blisters/oral lesions?	
96 Are you aware of any swelling or lumps?	
97 Sore, bleeding gums?	
98 Loose teeth?	
99 Difficulty chewing?	
100 Food catches between teeth?	
101 Teeth/filling break frequently?	
102 Clenching or grinding habits?	
103 Do you hear popping, clicking or snapping?	
104 Do you have jaw pain?	
105 Are you nervous about dental work?	

Patient Signature:_____ Date:_____

For Office Use Only

Dental Provider Acknowledgement:

I have reviewed the above medical, dental and social histories with the patient and have complete and accurate information to provide a clinical diagnosis and recommend appropriate treatment options.

Provider Signature: _____ Date: _____