

**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		Yes
8 Under physician's care?	<input type="checkbox"/>	34 Asthma?	<input type="checkbox"/>
Details:		35 Sleep Apnea?	<input type="checkbox"/>
9 Hospitalization/operation(s) in last 5 years?	<input type="checkbox"/>	36 Tuberculosis?	<input type="checkbox"/>
Details:		37 Sinus trouble?	<input type="checkbox"/>
10 Head/neck/mouth injuries?	<input type="checkbox"/>	38 Cancer?	<input type="checkbox"/>
11 Women: pregnant?	<input type="checkbox"/>	39 Radiation Treatment to Head/Neck?	<input type="checkbox"/>
12 Women: nursing?	<input type="checkbox"/>	40 Chemotherapy?	<input type="checkbox"/>
13 Women: oral contraceptives?	<input type="checkbox"/>	41 Kidney Disease?	<input type="checkbox"/>
14 Heart trouble/disease?	<input type="checkbox"/>	42 Dialysis?	<input type="checkbox"/>
15 Rheumatic fever?	<input type="checkbox"/>	43 Eating Disorder?	<input type="checkbox"/>
16 Past use of Fenphen?	<input type="checkbox"/>	44 Stomach: reflux? ulcer?	<input type="checkbox"/>
17 Heart murmur?	<input type="checkbox"/>	45 Immunological disease?	<input type="checkbox"/>
18 Mitral valve prolapse?	<input type="checkbox"/>	46 Sjogrens Disease?	<input type="checkbox"/>
19 Heart surgery?	<input type="checkbox"/>	47 Fibromyalgia?	<input type="checkbox"/>
20 Artificial heart valves?	<input type="checkbox"/>	48 Other autoimmune disease (lupus, pemphilus)?	<input type="checkbox"/>
21 Pacemaker?	<input type="checkbox"/>	49 Arthritis or other joint disorders?	<input type="checkbox"/>
22 Indwelling defibrillator?	<input type="checkbox"/>	50 Diabetes? Type: _____ Controlled? Y N	<input type="checkbox"/>
23 Artificial joints?	<input type="checkbox"/>	51 Headaches?	<input type="checkbox"/>
24 History of Organ Transplant?	<input type="checkbox"/>	52 Depression: Diagnosed?	<input type="checkbox"/>
25 High blood pressure? BP: /	<input type="checkbox"/>	53 Other Psychiatric Disorders?	<input type="checkbox"/>
26 Stroke?	<input type="checkbox"/>	54 Neurologic Disease?	<input type="checkbox"/>
27 Bleeding problem?	<input type="checkbox"/>	55 Convulsions?	<input type="checkbox"/>
28 Hemophilia?	<input type="checkbox"/>	56 Epilepsy/seizures?	<input type="checkbox"/>
29 Anemia?	<input type="checkbox"/>	57 Cerebral Palsy?	<input type="checkbox"/>
30 Leukemia?	<input type="checkbox"/>	58 Fainting/dizziness?	<input type="checkbox"/>
31 Lung disease?	<input type="checkbox"/>	59 Venereal disease?	<input type="checkbox"/>
32 Emphysema?	<input type="checkbox"/>	60 AIDS/HIV positive?	<input type="checkbox"/>
33 Shortness of Breath?	<input type="checkbox"/>	61 Alcohol or chemical dependency?	<input type="checkbox"/>
		62 Hepatitis?	<input type="checkbox"/>
		63 Thyroid disease?	<input type="checkbox"/>
		64 Glaucoma?	<input type="checkbox"/>

**TOBACCO**

65 Tobacco user?	Yes
Type:	
Amount:	
Number of years:	
66 How soon after wake up do you use tobacco? <div style="text-align: center;">&lt;30 minutes    &gt;30 minutes</div>	
67 Previous attempts to quit?	Yes
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:**

82 One or more fillings in the last three years?	Yes
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 temporomandibular 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: \_\_\_\_\_