MEDICAL – DENTAL HISTORY

PATIENT NAME _____ DATE OF BIRTH _____ TODAY'S DATE _____

NAME OF PATIENT'S PHYSICIAN _____ TELEPHONE _____ CITY _____

Main Reason for my dental visit is: _____

_____

_____

Date of Last Dental Examination (MM/YY)_____

Do you fear receiving Dental Care? ☐ Yes ☐ No

Have you experienced an unusual or allergic reaction to any of the following?

☐ Local Anesthetic ☐ Latex ☐ Aspirin ☐ Narcotics ☐ Penicillin ☐ Sulfa Drugs

☐ Metals ☐ Others Please describe experience.

_____

Do you regularly take any of the following? ☐ Ginseng ☐ Garlic ☐ Ginger ☐ Ginkgo

☐ Echinacea ☐ Ephedrine ☐ St. John's Wart

Please List All Medications you are currently taking (including over-the-counter, supplements and herbal). **Please provide list if taking more than 3 medications.**

Name:	Medical Condition:
_____	_____
_____	_____
_____	_____

Have You Had any Major Operations? ☐ Yes ☐ No

_____

_____

Do You Feel Safe at Home? ☐ Yes ☐ No

Do You Have Access To Medical Care? ☐ Yes ☐ No

Tobacco Use

Cigarettes

☐ Quit: Date _____

☐ Current Smoker: Packs/Day_____ # years _____

☐ Never

Other Tobacco:

☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Betel Quid ☐ Vaping

Are You Interested in Quiting? ☐ Yes ☐ No

Alcohol Use

Do you drink Alcohol? ☐ Yes ☐ No # Drinks/Week _____

Drug Use ☐ Yes ☐ No

Do You Use Recreational Drugs? ☐ Yes ☐ No

Have you Ever Used Needles? ☐ Yes ☐ No

The Following Information is Essential for the Safe and Effective Diagnosis of Each Patient.

Do You Have or Have You Ever Had Any of the Following?

CARDIOVASCULAR

☐ Yes Congenital Heart Disease or Cardiac Transplant
☐ Yes Artificial Heart Valve
☐ Yes High Blood Pressure
☐ Yes Low Blood Pressure
☐ Yes Angina/Chest Pain
☐ Yes Heart Pacemaker
☐ Yes Heart Attack
☐ Yes Heart Surgery
☐ Yes Stroke/Paralysis

GENERAL

☐ Yes Cancer
☐ Yes Radiation Therapy
☐ Yes Chemotherapy
☐ Yes Difficulty Hearing
☐ Yes Eye Problems
☐ Yes Drug/Alcohol Treatment
☐ Yes **Women Only**: Are you or could you be **pregnant**?

RESPIRATORY

☐ Yes Asthma
☐ Yes Breathing Problems (Sleep Apnea, Emphysema, Shortness of Breath, Oxygen Dependent, Cough)
☐ Yes Tuberculosis

HEMATOLOGY

☐ Yes Bleeding/Bruising easily Blood Disorder
☐ Yes Immune System (Lupus, Immunodeficiency, Sjogrens)

INFECTIOUS DISEASE

☐ Yes HIV/AIDS
☐ Yes Herpes
☐ Yes Hepatitis A, B or C

MUSCULOSKELETAL

☐ Yes Osteoporosis/Bisphosphonate Therapy
☐ Yes Rheumatism/Arthritis
☐ Yes Artificial Joint

ENDOCRINE

☐ Yes Diabetes: Type 1 Type 2
☐ Yes Steroid Treatment (Cortisone)
☐ Yes Thyroid Problem

NEUROLOGY

☐ Yes Memory Loss
☐ Yes Seizures/Epilepsy
☐ Yes Psychiatric Treatment
☐ Yes Fainting/Dizziness

GASTROINTESTINAL

☐ Yes Reflux/GERD
☐ Yes Stomach/Intestinal Disease/ Ulcers
☐ Yes Liver Disease/Yellow Jaundice
☐ Yes Kidney Disease

Do You Have Any Other Medical Conditions Not Listed?

_____

_____

_____

_____