DENTAL AND MEDICAL HISTORY FORM

General Information:

Patient's Name: ______________________________ Patient's Birth Date: ____________

Do you use tobacco products? Yes ☐ No ☐ If yes, type and frequency: ______________________________

Dental History:

Approximate date of last dental exam: ____________________

What treatments were performed at your last dental appointment? ______________________________

Are you aware of any unfinished treatment? ______________________________

If we do not already have the information, may we request your dental records from your previous dentist? Yes ☐ No ☐

If yes, previous Dentist's Name and Address/Phone: ______________________________

Are you currently experiencing pain or discomfort in or near your mouth? Yes ☐ No ☐

If yes, please describe: ______________________________

Have you ever had a bad dental experience? Yes ☐ No ☐

If yes, please describe: ______________________________

Is there anything you don't like about your smile? ______________________________

Medical History:

Approximate date of last physical exam: ____________________

Do you take a Premedication for dental procedures? **Yes** ☐ **No** ☐ If yes, what medication: ____________________

Are you currently under the care of a Physician? **Yes** ☐ **No** ☐

Please indicate any allergies, including to medications: ______________________________

Have you been hospitalized or undergone surgery of any kind? Please describe: ______________________________

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Medications List: If you are currently taking medications, please list below. If you have a list, we can copy it for convenience.

Drug Name	Why do you take this?	Dosage

Continued on back…

Health Conditions: Please explain any ***Yes*** answers in more detail below:

Name	Yes	No	Name	Yes	No	Name	Yes	No
AIDS/HIV Positive	☐	☐	Emphysema	☐	☐	Nervous Problems / Anxiety	☐	☐
Alzheimer's Disease	☐	☐	Epilepsy or Seizures	☐	☐	Osteoporosis	☐	☐
Anaphylaxis	☐	☐	Fainting Spells/Dizziness	☐	☐	Parathyroid Disease	☐	☐
Anemia	☐	☐	Frequent Cough	☐	☐	Psychiatric Care	☐	☐
Angina	☐	☐	Frequent Diarrhea	☐	☐	Radiation Treatments	☐	☐
Arthritis/Gout	☐	☐	Frequent Headaches	☐	☐	Rheumatic Fever	☐	☐
Artificial Heart Valve	☐	☐	Genital Herpes	☐	☐	Scarlet Fever	☐	☐
Artificial Joint	☐	☐	Glaucoma	☐	☐	Shingles	☐	☐
Asthma	☐	☐	Heart Attack/Stroke	☐	☐	Sickle Cell Disease	☐	☐
Blood Disease	☐	☐	Heart Valve Replacement	☐	☐	Sinus Problems	☐	☐
Blood Transfusions	☐	☐	Heart Surgery/Pacemaker	☐	☐	Skin Rash / Hives	☐	☐
Breathing Difficulty	☐	☐	Hemophilia/Excess Bleeding	☐	☐	Spina Bifida	☐	☐
Bruise Easily	☐	☐	Hepatitis, Type: _______	☐	☐	Stomach/Intestinal Disease	☐	☐
Cancer	☐	☐	High / Low Blood Pressure	☐	☐	Swelling of Limbs or Feet	☐	☐
Chemotherapy	☐	☐	Hyperlipidemia	☐	☐	Swelling of Neck Glands	☐	☐
Chest Pains	☐	☐	Jaundice	☐	☐	Thyroid Disease	☐	☐
Cold Sores/Oral Herpes	☐	☐	Jaw Problems /TMJ /TMD	☐	☐	Tonsillitis	☐	☐
Congenital Heart Disorder	☐	☐	Kidney Problems	☐	☐	Tuberculosis (TB)	☐	☐
Convulsions	☐	☐	Liver Disease	☐	☐	Tumor / Growth	☐	☐
Cortisone Medicine / Steroids	☐	☐	Lung Disease	☐	☐	Ulcers	☐	☐
Diabetes / Hypoglycemia	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease/STD	☐	☐
Drug / Alcohol Addiction	☐	☐	Neck or Back Problems	☐	☐	Weight Loss (unexplained)	☐	☐

Please explain yes answers from above with more detail if needed, or note anything else we should be aware of:

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Date	Changes to your medical history	Pt. Initials	Dr. Initials

I attest that the information I have provided above is accurate and complete to the best of my knowledge:

Patient's Signature: ____ Date: _____________

Doctor's Signature: ____