## IV. Medical and Dental Health History

Patient Name: Date:

### A. Medical Health Information

1. Do you have or have you had any of the following medical conditions or symptoms? ❑ No ❑ Yes:

| | | | |
|---|---|---|---|
| ❑ Anemia | ❑ Excessive bleeding | ❑ Intestinal problems | ❑ Respiratory problems |
| ❑ Arthritis | ❑ Glaucoma | ❑ Jaundice | ❑ Rheumatic Fever |
| ❑ Artificial Joints/hip | ❑ Growths | ❑ Kidney Disease | ❑ Rheumatism |
| ❑ Asthma | ❑ Head injuries | ❑ Liver Disease | ❑ Sinus problems |
| ❑ Blood Disease | ❑ Heart Disease | ❑ Mitral Valve Prolapse | ❑ Stroke |
| ❑ Bone/joint problems | ❑ Heart Murmur | ❑ Mental disorders | ❑ Thyroid problems |
| ❑ Cancer | ❑ Hepatitis | ❑ Nervous disorders | ❑ Tuberculosis |
| ❑ Diabetes | ❑ Herpes | ❑ Pacemaker | ❑ Tumors |
| ❑ Dizziness or fainting | ❑ High Blood Pressure | ❑ Persistent cough | ❑ Ulcers |
| ❑ Epilepsy | ❑ HIV | ❑ Radiation treatment | ❑ Venereal or STD(s) |

Do you have any medical disease, condition or problem not listed above you feel we should know about?

2. Are you currently taking any medications? ❑ No ❑ Yes

❑ a. Contraceptives or other hormone medication(s):

❑ b. Vitamins, herbal remedies or OTC (over-the-counter) medications:

| Name of medication: | For: | Date started (approximately): |
|---|---|---|
| c. | | |
| d. | | |
| e. | | |
| f. | | |
| g. | | |
| h. | | |

3. Are pre-medications required by your physician before receiving dental treatment?

❑ No ❑ Yes ❑ Unsure/Don't Know:

4. Name of Physician: Phone Number:

5. Please complete this section if you are female:

a. Are you pregnant? ❑ No ❑Yes ❑Maybe/Other:

b. Are you currently nursing? ❑ No ❑Yes

c. Have you reached menopause? ❑ No ❑ Yes ❑ Maybe/Other:

If yes, do you have any symptoms or problems?

## B. Dental Health Information

1. Do you have any of the following types of allergies? ❑ No ❑ Yes:

| | |
|---|---|
| ❑ Aspirin, Acetaminophen or Ibuprophen | ❑ Local anesthetics (such as "Novocaine") |
| ❑ Barbituates, sedatives or sleeping pills | ❑ Penicillin |
| ❑ Codeine, Demeraol or other narcotics | ❑ Other Antibiotics: |
| ❑ Fluoride | ❑ Sulfa Drugs |
| ❑ Hayfever | ❑ Other: |
| ❑ Latex or rubber dam | ❑ Other: |

Do you have any allergies not listed above?

2. Does anyone in your biological family have a history of:

| | | |
|---|---|---|
| ❑ Cancer | ❑ Drug or Alcohol Abuse | ❑ High Blood Pressure |
| ❑ Diabetes | ❑ Heart Disease | ❑ None |

3. Do you wear contact lenses? ❑ No ❑ Yes

4. Do you smoke? ❑ No ❑ Yes If Yes, how much?

5. Please indicate if you have, or have had, any of the following conditions or experiences:

| a. Head and Neck | c. Teeth |
|---|---|
| ❑ A history of head or neck injury | ❑ Difficulty opening or closing the mouth or jaw |
| ❑ Difficulty opening or closing the mouth or jaw | ❑ Clenching or grinding |
| ❑ Frequent or severe headaches | ❑ Difficulty chewing |
| ❑ Pain to any areas of the head or neck | ❑ Food gets caught between teeth |
| ❑ Soreness around the jaw, ear or side of face | ❑ Sensitivity |
| ❑ TMJ or jaw joint problems | ❑ Painful areas or twinges of pain |
| **b. Soft Tissues** | **d. Gums** |
| ❑ A history of injury to cheeks, lips, or throat | ❑ A history of injury to tissues inside of mouth |
| ❑ Biting of lips or cheeks | ❑ Bleeding gums during flossing or at other times |
| ❑ Lumps or sores in mouth | ❑ Lumps or sores on gums |
| ❑ Slow healing sores in mouth | ❑ Painful areas or twinges of pain |
| ❑ Strong tendency to gag easily | ❑ Prolonged bleeding following a tooth extraction |
| ❑ Tenderness at the roof of mouth | ❑ Sensitivity |

e. Do you have any other conditions, problems or concerns not addressed above?

6. Which of the following applies to you? (Select all that apply)

| | |
|---|---|
| ❑ I am satisfied with the general health of my teeth and gums. | ❑ Keeping my teeth for as long as possible is important to me. |
| ❑ I am content with the way teeth look (color, etc.) | ❑ Other: |
| ❑ I brush and floss twice every day. | |

| *updates and changes* | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|