

**Medical History Form 2021**

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

**Dental Questions**

- Do you have any concerns with your teeth, gums, or smile?  Yes  No If yes
- Please describe.
- Are you having any pain or discomfort, or trouble chewing at this time? Please describe.  Yes  No If yes
- Do you have any growths or sores in or around your mouth? Please describe.  Yes  No If yes
- Have you ever been told you have gingivitis or gum disease?  Yes  No If yes

When was your last dental appointment? Name and address of previous dentist if you are a new patient.

Primary Medical Doctor - Name, Address, and Phone Number.

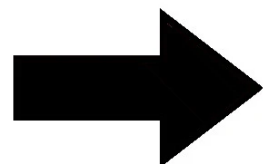
Are you taking any Prescriptions, Medications, Pills, or Drugs? Please List. If you have a copy, you may give that to the front desk to scan.

- Has your physician ever requested you to take an antibiotic before dental treatment? If yes, what antibiotic and why.  Yes  No If yes
- Are you under a physician's care for any medical issues at this time?  Yes  No If yes
- Have you been hospitalized or had a major operation in the last 2 years?  Yes  No If yes
- Have you ever had a serious head or neck injury?  Yes  No If yes
- Do you use tobacco, E-Cigs, controlled substances, Marijuana or other drugs?  Yes  No If yes
- Do you have an ALLERGY to latex or any MEDICATIONS? Or had any adverse reactions to any substance?  Yes  No If yes

WOMEN: ARE YOU CURRENTLY...

Pregnant/Trying to get pregnant?
  Nursing?
  Taking oral contraceptives?

SEE REVERSE SIDE



Do you have, or have you had, any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive                       | <input type="checkbox"/> Artificial Joint/ Replacement | <input type="checkbox"/> Artificial Heart Valve/ Replacement     |
| <input type="checkbox"/> Mitral Valve Prolapse/ Damaged Heart Va | <input type="checkbox"/> Heart Attack/ Stroke          | <input type="checkbox"/> Heart Murmur/ Congenital Heart Conditio |
| <input type="checkbox"/> Pacemaker/ Defibrillator                | <input type="checkbox"/> Heart Surgery                 | <input type="checkbox"/> Congestive Heart Failure                |
| <input type="checkbox"/> Hemophilia/ Blood Transfusion           | <input type="checkbox"/> High or Low Blood Pressure    | <input type="checkbox"/> Hepatitis                               |
| <input type="checkbox"/> TB Tuberculosis                         | <input type="checkbox"/> Rheumatic Fever               | <input type="checkbox"/> Thyroid Problems                        |
| <input type="checkbox"/> Diabetes                                | <input type="checkbox"/> Epilepsy or Seizures          | <input type="checkbox"/> Mental Health Disorder                  |
| <input type="checkbox"/> Cancer - Chemotherapy/ Radiation        | <input type="checkbox"/> Acid Reflux/ Heartburn        | <input type="checkbox"/> Oral Habits - Nail / Lip / Cheek Biting |
| <input type="checkbox"/> Dry Mouth                               | <input type="checkbox"/> Mouth Breathing               | <input type="checkbox"/> Orthodontics/ Braces                    |
| <input type="checkbox"/> Periodontal Treatment/ Gum Surgery      |  |  |

Have you ever had any serious illness not listed above?

Yes  No

If yes

Is there anything else we should know about your Medical or Dental History? Please explain.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: \_\_\_\_\_