Malinoski _Associates, D.D.S., P.C

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? Please describe.	◯ Yes ◯ No	If yes
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?

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