Medical History 1

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 relationship with the dentistry you deserve. Thank you for answering the following questions.

Have you been under the care of a physician during the past two years? If yes, for what? ◯ Yes ◯ No If yes

What is the date of your last physical exam?

What is the name of your hospital or clinic?

What is the name and phone number of your physican?

What is the name and phone number of your pharmacy?

Have you ever been hospitalized or had a major operation? If yes, please describe. ◯ Yes ◯ No If yes

Have you ever been told to take a premedication before dental appointments? ◯ Yes ◯ No

Do you smoke? If yes, how much per day and for how many years? ◯ Yes ◯ No If yes

Do you use e-cigarettes? If yes, how much per day and for how many years? ◯ Yes ◯ No If yes

Do you regularly hold anything inside the cheek, including tobacco? If yes, how often and for how many years? ◯ Yes ◯ No If yes

Have you ever had an allergic or adverse reaction to any of the following?

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Hay fever
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Seasonal
- ☐ Sulfa Drugs

Have you ever had an allergic or adverse reaction to something not listed above? If yes, describe the reaction. ◯ Yes ◯ No If yes

For women, are you:

- ☐ pregnant/trying to get pregnant?
- ☐ nursing?
- ☐ taking oral contraceptives?

For pregnant women, how many months?

Cardiovascular

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

- ☐ Aneurysm
- ☐ Artificial/Prosthetic Heart Valve
- ☐ Chest Pain
- ☐ Congenital Heart Defect
- ☐ Congestive Heart Failure
- ☐ Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Heart Transplant
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker/Defibrillator
- ☐ Rheumatic Fever
- ☐ Stroke

Dermatologic

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

- ☐ Changes in appearance of Moles
- ☐ Chicken Pox
- ☐ Eczema
- ☐ Night Sweats
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Shingles

Endocrine

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

- ☐ Diabetes
- ☐ Gout
- ☐ Hormonal Dysfunction
- ☐ Hypoglycemia
- ☐ Parathyroid Disease
- ☐ Thyroid Disease

Gastrointestinal

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

- ☐ Chron's Disease
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Eating Disorder
- ☐ Hepatitis
- ☐ Persistent Diarrhea
- ☐ Recent Weight Loss or Gain
- ☐ Special or Restricted Diet
- ☐ Stomach or Intestinal Ulcers
- ☐ Tonsils Removed
- ☐ Yellow Jaundice

Genitourinary

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

- [ ] AIDS or HIV positive
- [ ] Chlamydia
- [ ] Dialysis
- [ ] Genital Herpes
- [ ] Gonorrhea
- [ ] Human Papilloma Virus
- [ ] Kidney or Bladder Problem
- [ ] Kidney Transplant
- [ ] Multiple Sexual Partners
- [ ] Syphilis
- [ ] Urinate Frequently

Hematologic

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

- [ ] Anemia
- [ ] Blood Transfusion
- [ ] Excessive Bleeding
- [ ] Hemophilia
- [ ] Leukemia
- [ ] Sickle Cell Anemia

Musculoskeletal

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

- [ ] Ankylosing Spondylitis
- [ ] Artificial/Prosthetic Joint Replacement
- [ ] Fatigue
- [ ] Fibromyalgia
- [ ] Muscular Dystrophy
- [ ] Neurofibromatosis
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Rheumatoid Arthritis
- [ ] Spina bifida
- [ ] Systemic Lupus

Neurologic

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

- [ ] ADHD
- [ ] Alcohol or Drug Abuse
- [ ] Alzheimer's
- [ ] Cerebral Palsy
- [ ] Depression
- [ ] Developmental Disability
- [ ] Earaches, Ringing in Ears
- [ ] Epilepsy, Seizures or Convulsions
- [ ] Fainting or Dizzy Spells
- [ ] Glaucoma
- [ ] Hearing Loss
- [ ] Multiple Sclerosis
- [ ] Nervousness or Anxiety
- [ ] Panic Attacks
- [ ] Phobias
- [ ] Schizophrenia
- [ ] Severe Headaches
- [ ] Vision Problems

Respiratory

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

- [ ] Allergies or Hives
- [ ] Asthma
- [ ] Bloody Sputum
- [ ] Breathing Problems
- [ ] Bronchitis
- [ ] Chronic Cough
- [ ] COPD
- [ ] Emphysema
- [ ] Pneumonia
- [ ] Sinus Trouble
- [ ] Tuberculosis

Other Conditions

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

- [ ] Cancer or Tumor
- [ ] Chemotherapy
- [ ] High Fever before age two
- [ ] Radiation Therapy
- [ ] Recurring Infection of any kind
- [ ] Trauma/Injury to the head and neck

Have you have, or have you ever had, a disease, condition, or problem not listed on this form? ◯ Yes ◯ No If yes

Medications

Are you taking, or have you ever taken, any of the following medications?

- [ ] Aspirin
- [ ] Drugs to assist in weight loss/gain
- [ ] Blood thinners
- [ ] Drugs for bone health
- [ ] High blood pressure meds
- [ ] Ibuprofen
- [ ] Insulin
- [ ] Steroids/cortisone

Are you taking any pills, drugs, over-the-counter meds, herbal or nutritional supplements? Provide copy or list here: ◯ Yes ◯ No If yes

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