



## MEDICAL HISTORY FORM

Your Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Home Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: \_\_\_\_\_ Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Gender: M / F

Marital Status: \_\_\_\_\_ Email: \_\_\_\_\_

What is your primary reason or concern for contacting us? \_\_\_\_\_

Approximate last date of dental visit: \_\_\_\_\_ Reason: \_\_\_\_\_

**Referral Information:** Who may we thank for referring you to our practice? \_\_\_\_\_

**Please check any/all conditions that apply:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> HIV / AIDS          | <input type="checkbox"/> Codeine Allergy         | <input type="checkbox"/> Dental Implants                              |
| <input type="checkbox"/> Latex Allergy       | <input type="checkbox"/> Penicillin Allergy      | <input type="checkbox"/> Periodontal Disease (past/current)           |
| <input type="checkbox"/> Artificial Joint/s  | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> History of Root Canal/s                      |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> History of Orthodontics (braces/Invisalign)  |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Have your wisdom teeth extracted?            |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Teeth Whitening (in-office / trays / strips) |
| <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Use an electric toothbrush?                  |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Defibrillator           |   |
| <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Head Injury             |   |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Heart Murmur            |   |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> High/Low Blood Pressure |   |
| <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Kidney Disease          |   |
| <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Mental Disorder/s       |   |
| <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Pacemaker               |   |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems    | <input type="checkbox"/> Smoke or other tobacco use?                  |
| <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Birth Control                                |
| <input type="checkbox"/> Sinus Problem/s     | <input type="checkbox"/> Stomach Problems        | <input type="checkbox"/> Illicit Drug use (name) _____                |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Tuberculosis            |   |
| <input type="checkbox"/> Tumor/s             | <input type="checkbox"/> Dialysis                |   |

**Do you have any other condition not listed above or significant dental or general health problem that may need further clarification?**

No  Yes If yes, please briefly explain: \_\_\_\_\_

**Do you have any allergies?**  No  Yes

If yes, please list name and reaction: \_\_\_\_\_

**Are you currently taking any medications?**  No  Yes

If yes, please list: \_\_\_\_\_

**Have you ever had to take pre-medication prior to a dental appointment, such as antibiotic prophylaxis?**  No  Yes

If yes, please briefly explain: \_\_\_\_\_

**Have you ever had any complications following dental treatment?**  No  Yes

If yes, please briefly explain: \_\_\_\_\_

**Have you recently been admitted to the hospital or needed emergency care?**  No  Yes

If yes, please briefly explain: \_\_\_\_\_

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

If yes, name of physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason: \_\_\_\_\_

**Women:**

**Is there a possibility you are currently pregnant?**  No  Yes

If yes, please provide current trimester: \_\_\_\_\_ estimated due date: \_\_\_\_\_

**In Case of Emergency, whom should we contact on your behalf?**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Help us help you:**

- |   |       |
|---|-------|
| 1. Are you interested in whitening your teeth?                                      | Y / N |
| 2. Are you interested in straightening your teeth?                                  | Y / N |
| 3. Are you interested in improving your smile?                                      | Y / N |
| 4. Are you interested in knowing more about the benefits of an electric toothbrush? | Y / N |
| 5. Are you interested in replacing missing teeth?                                   | Y / N |
| 6. Do you grind or clench your teeth?   | Y / N |

*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: \_\_\_\_\_

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