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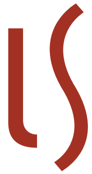

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Medical & Dental History Form

Patient Name: ____

Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Please mark any of the following to indicate YES in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked, please explain: ____

____

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WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No If Yes, then when is the due date: ______________

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? ______________________________

PLEASE LIST ALL OF YOUR MEDICATION(S) including non-prescription medicine: ______________________________

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Please indicate if you have experienced any of the following:

☐ Alcohol/Drug Abuse	☐ Cancer	☐ Heart Murmur	☐ Rheumatic Fever
☐ Allergy - Codeine	☐ Canker Sores	☐ Hepatitis - Type ____	☐ Rheumatism
☐ Allergy - Hay Fever	☐ Diabetes	☐ High Blood Pressure	☐ Sinus Problems
☐ Allergy - Latex	☐ Dizziness	☐ HIV	☐ Stomach Problems
☐ Allergy - Penicillin	☐ Dry Mouth	☐ Jaundice	☐ Stroke
☐ Allergy - Sulfa	☐ Epilepsy	☐ Kidney Disease	☐ Tuberculosis
☐ Allergy-Other ________	☐ Excessive Bleeding	☐ Liver Disease	☐ Tumors
☐ Anemia	☐ Fainting	☐ Mental Disorders	☐ Ulcers
☐ Arthritis	☐ Glaucoma	☐ Nervous Disorders	☐ Other ________
☐ Artificial Joints	☐ Growths	☐ Pacemaker	________
☐ Asthma	☐ Headaches	☐ Pregnancy	________
☐ Bad Breath	☐ Head Injuries	☐ Radiation Treatment	
☐ Blood Disease	☐ Heart Disease	☐ Respiratory Problems	

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature of patient, parent, or guardian: ______________________________ Date: ______________

Relationship to Patient: ____