Medical Dental History Form

Patient Name: _____ Physician: _____

Allergies to:

Latex: Yes No

Medications: _____

Other: _____

Height: _____ Weight: _____

Pre-Med Required? Yes No

Check if you have had any problems with the following:

- ☐ Bad breath
- ☐ Bleeding, sensitive gums
- ☐ Clicking or popping jaw: right or left
- ☐ Food trapped between teeth
- ☐ Grinding or clenching teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Sores in mouth
- ☐ Staining

Current Medications (Prescription, Over the Counter and Herbal)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Past and Current Medical Conditions (Check all that apply)

- ☐ AIDS / HIV Positive
- ☐ Alcoholism
- ☐ Allergies

Describe _____

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulation problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough, up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches, frequent
- ☐ Headaches, migraines
- ☐ Heart murmur
- ☐ Heart, any problems

Describe _____

- ☐ Hemophilia
- ☐ Herpes
- ☐ Hepatitis A B C
- ☐ High blood pressure
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Seizure disorders
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Surgical implants
- ☐ Swelling, feet or ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Ulcers/colitis

Women:

___ Pregnant

___ Nursing

___ Oral Contraceptives

Other: _____

Have you ever responded adversely to medical or dental treatment? Y N

If yes, please explain: _____

Are you under the care of the physician? Y N

If yes, please explain: _____

Is there anything you feel we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitles. I will not hold my dentist or any of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____