MEDICAL & DENTAL HEALTH HISTORY FORM

MEDICAL HISTORY

Physician Name: _____ Phone: _____

Date of Last Physical Exam: _____

Current Dentist: _____ Last Dental Visit: _____

Reason for Today's Visit: _____

Please check all medical conditions that apply:

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes Type I
- ☐ Liver Disease
- ☐ HIV/AIDS
- ☐ COPD
- ☐ Cancer
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Seizures/Epilepsy
- ☐ Mental Health Condition
- ☐ Stomach Ulcers
- ☐ Glaucoma
- ☐ Autoimmune Disease
- ☐ Pregnancy
- ☐ Heart Murmur
- ☐ Low Blood Pressure
- ☐ Diabetes Type II
- ☐ Hepatitis A
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Chemotherapy
- ☐ Rheumatoid Arthritis
- ☐ Hemophilia
- ☐ Fainting/Dizziness
- ☐ Depression
- ☐ Acid Reflux/GERD
- ☐ Vision Problems
- ☐ Lupus
- ☐ Nursing
- ☐ Heart Attack
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Hepatitis B
- ☐ Asthma
- ☐ Bronchitis
- ☐ Radiation Therapy
- ☐ Joint Replacement
- ☐ Anemia
- ☐ Headaches/Migraines
- ☐ Anxiety
- ☐ Crohn's Disease
- ☐ Hearing Problems
- ☐ Multiple Sclerosis
- ☐ Hormone Therapy
- ☐ Angina
- ☐ Pacemaker
- ☐ Kidney Disease
- ☐ Hepatitis C
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Leukemia
- ☐ Osteoporosis
- ☐ Blood Transfusion
- ☐ Neurological Disorder
- ☐ Bipolar Disorder
- ☐ Colitis
- ☐ Sinus Problems
- ☐ Fibromyalgia
- ☐ Birth Control Pills

List All Allergies (medications, latex, foods, environmental, etc.):

_____

_____

List All Current Medications (include dosage and frequency):

_____

_____

_____

_____

Recent Hospitalizations or Surgeries (include dates):

_____

_____

_____

MEDICAL & DENTAL HEALTH HISTORY FORM (continued)

DENTAL & PERIODONTAL HISTORY

Please check any dental concerns you are experiencing:

- ☐ Bleeding Gums
- ☐ Swollen Gums
- ☐ Receding Gums
- ☐ Loose Teeth
- ☐ Sensitive Teeth
- ☐ Bad Breath
- ☐ Pain/Discomfort
- ☐ Difficulty Chewing
- ☐ Clicking/Popping Jaw
- ☐ Grinding/Clenching
- ☐ Dry Mouth
- ☐ Sores/Lesions

Oral Hygiene Habits:

How often do you brush your teeth? _____

How often do you floss? _____

Do you use mouthwash? ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No If yes, type/frequency: _____

Additional Information or Concerns:

_____

_____

_____

CONSENT & SIGNATURE

I certify that the above information is complete and accurate to the best of my knowledge. I understand that this information is confidential and will be used only for treatment purposes. I agree to inform the office of any changes to my health status. I authorize the dental staff to perform necessary dental procedures and understand that I am financially responsible for all charges.

Patient/Guardian Signature: _____ Date: _____