

Medical History Form 2020 (updated from 2018)

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, c

Name of your current physician  Yes  No If yes \_\_\_\_\_

Surgical Operations

Appendectomy  Yes  No Back  Yes  No Ear  Yes  No Gallbladder  Yes  No
Heart  Yes  No Hernia repair  Yes  No Lung  Yes  No Nasal  Yes  No
Thyroid  Yes  No Tonsillectomy  Yes  No Uvulectomy  Yes  No Periodontal  Yes  No
Other:  Yes  No If yes \_\_\_\_\_

Family History

Has any member of your family (parent, sibling, or grandparent) had:

Cancer  Yes  No Heart disease  Yes  No Diabetes  Yes  No High blood pressure  Yes  No
Stroke  Yes  No Sleep disorder  Yes  No Obesity  Yes  No Thyroid disorder  Yes  No
Father snores  Yes  No Mother snores  Yes  No Father has sleep apnea  Yes  No Mother has sleep apnea  Yes  No

Social History

Are you a tobacco user of one of the following:

Cigarettes  Yes  No Pipe  Yes  No Cigar  Yes  No Snuff  Yes  No
Chew  Yes  No Never used  Yes  No

Currently smoking? How many packs a day?  Yes  No If yes \_\_\_\_\_

Quit smoking? When did you quit?  Yes  No If yes \_\_\_\_\_

Caffeine intake:

none  Yes  No Coffee  Yes  No Tea  Yes  No Soda  Yes  No

Drink Caffeine? How much do you drink daily?  Yes  No If yes \_\_\_\_\_

Do you drink alcohol? # of drinks per week?  Yes  No If yes \_\_\_\_\_

Do you exercise? How often?  Yes  No If yes \_\_\_\_\_

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Do you have any allergens to the following?

Aspirin  Penicillin  Codeine  Acrylic
 Metal  Latex  Sulfa Drugs  Local Anesthetics
 Antibiotics  Sedatives  Sleeping pills  No known allergens

Other:  If yes \_\_\_\_\_

Are you currently taking any medication? List:  If yes \_\_\_\_\_

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

AIDS/HIV Positive  Yes  No Cortisone Medicine  Yes  No Hemophilia  Yes  No Radiation Treatments  Yes  No
Diabetes  Yes  No Hepatitis  Yes  No Anaphylaxis  Yes  No Drug Addiction  Yes  No
Renal Dialysis  Yes  No Anemia  Yes  No Rheumatic Fever  Yes  No Angina  Yes  No
Emphysema  Yes  No High Blood Pressure  Yes  No Arthritis/Gout  Yes  No Epilepsy or Seizures  Yes  No
High Cholesterol  Yes  No Artificial Heart Valve  Yes  No Artificial Joint  Yes  No Hypoglycemia  Yes  No
Asthma  Yes  No Fainting Spells/Dizziness  Yes  No Sinus Trouble  Yes  No Frequent Cough  Yes  No
Kidney Problems  Yes  No Frequent Headaches  Yes  No Liver Disease  Yes  No Stroke  Yes  No
Bruise Easily  Yes  No Low Blood Pressure  Yes  No Cancer  Yes  No Glaucoma  Yes  No
Thyroid Disease  Yes  No Chemotherapy  Yes  No Hay Fever  Yes  No Mitral Valve Prolapse  Yes  No
Tonsillitis  Yes  No Chest Pains  Yes  No Heart Attack/Failure  Yes  No Osteoporosis  Yes  No
Tuberculosis  Yes  No Cold Sores/Fever Blisters  Yes  No Heart Murmur  Yes  No Pain in Jaw Joints  Yes  No
Tumors or Growths  Yes  No Heart Pacemaker  Yes  No Ulcers  Yes  No Heart Trouble/Disease  Yes  No
Psychiatric Care  Yes  No Acid reflux  Yes  No Atherosclerosis  Yes  No Bleed Easily  Yes  No
Chronic fatigue  Yes  No Chronic Pain  Yes  No COPD  Yes  No Coronary heart disease  Yes  No
Depression  Yes  No Difficulty sleeping  Yes  No Daytime Sleepiness  Yes  No Fibromyalgia  Yes  No
Immune system disorder  Yes  No Insomnia  Yes  No Ischemic heart disease  Yes  No Mood Disorder  Yes  No
Multiple sclerosis  Yes  No Nasal allergies  Yes  No Neuralgia  Yes  No Osteoarthritis  Yes  No
Parkinson's disease  Yes  No Prior Orthodontics  Yes  No Rheumatic arthritis  Yes  No Sleep apnea  Yes  No

If you marked "YES" please list below: Current Status and Date of Diagnosis  Yes  No

Empty box for listing current status and date of diagnosis for "YES" responses.

Do you have any other Medical Condition not listed above? Please list below with Current status and Date of Diagnosis  Yes  No

Empty box for listing other medical conditions not listed above.

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:

X

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