Medical/Dental Health History

Date Completed: ________________

Patient Last Name: ______________________________________ **First Name:** ____
Date of Birth: _________/___________/______ **Age:** __________________________ **Gender:** ____________________________
Name of person completing health questionnaire: ____________________________**Relationship to Patient:** _______________

Although dental personnel primarily treat in and around your mouth, your mouth is part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry your child will receive. Please answer each of the following questions individually.

Medical History

Please circle the appropriate answer:

Yes No 1. Do you have any health problems? If yes, describe:____

Yes No 2. Are you currently under medical care? If yes, for what? ____

Yes No 3. Have there been any changes in your health in the past year? If yes, please explain. ______________________

____

4. Do you have any of the following **Allergies?**

Allergies	Yes	No	Allergies	Yes	No
Aspirin	☐	☐	Metals	☐	☐
Codeine	☐	☐	Penicillin	☐	☐
Dental Anesthetics	☐	☐	Tetracycline	☐	☐
Erythromycin	☐	☐	Other ____________________________		
Latex	☐	☐	____________________________		

5. Do you have or have you ever had any of the following? *PLEASE MARK EACH BOX INDIVIDUALLY.*

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Abnormal bleeding	☐	☐	Fainting spells	☐	☐	Pervasive developmental disorder	☐	☐
ADHD/ADD	☐	☐	Fever blisters/cold sores	☐	☐	Pins, Screws, Plates	☐	☐
Anemia	☐	☐	Frequent headaches	☐	☐	Psychiatric problems	☐	☐
Anxiety	☐	☐	Hearing disorder	☐	☐	Radiation therapy	☐	☐
Arthritis	☐	☐	High/Low blood pressure	☐	☐	Respiratory problems	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐	Rheumatic fever	☐	☐
Autism Spectrum	☐	☐	Hearth murmur	☐	☐	Seasonal allergies	☐	☐
Blood disorder	☐	☐	Heart surgery	☐	☐	Seizures	☐	☐
Blood transfusion	☐	☐	Hemophilia	☐	☐	Sickle cell anemia	☐	☐
Cancer	☐	☐	Hepatitis A, B, or C	☐	☐	Sinus problems	☐	☐
Cerebral palsy	☐	☐	Intestinal problems	☐	☐	Stroke	☐	☐
Chemotherapy	☐	☐	Intellectual disability	☐	☐	Thyroid problems	☐	☐
Colitis	☐	☐	Kidney problems	☐	☐	Tuberculosis	☐	☐
Congenital heart defect	☐	☐	Liver Disease	☐	☐	Tumors	☐	☐
Depression	☐	☐	Muscular disorder	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	Neurological disorder	☐	☐	Visual disorders	☐	☐
Epilepsy	☐	☐	Obsessive compulsive disorder	☐	☐			
Joint replacement	☐	☐	Oppositional defiance disorder	☐	☐			
Facial surgery	☐	☐	Osteoporosis	☐	☐			

Adolescents/Adults (If older than age 12)

	Yes	No
Alcohol Abuse	☐	☐
Drug Abuse	☐	☐
Tobacco use	☐	☐
Sexually Transmitted Disease	☐	☐

Females: Adolescent/Adult

	Yes	No
Are you taking birth control pills?	☐	☐
Are you Pregnant?	☐	☐
If **YES**, Number of Weeks: ________________		
Are you nursing?	☐	☐

Medical/Dental Health History

Yes No 6. Have you ever been hospitalized or had any surgery? If yes describe: ___________________________
____
____

Yes No 7. Do you have or ever had any disease, condition, syndrome, or problem not listed here?
If yes, describe: ____
____
____

Yes No 8. Do you have any undiagnosed symptoms? If yes, describe: _____________________________________
____
____

Yes No 9. Are you **<u>taking any medication</u>** of any kind? If yes, please list: ___________________________________
____
____
____

Yes No 10. Do you require a **<u>PREMEDICATION/ANTIBIOTIC</u>** prior to any dental treatment? If yes, what medication? ____

Yes No 11. Have you ever taken any on these medications? If so, please circle.
Fosamax, Actonel, Boniva, Zometa, Atelvia, Reclast, or any other <u>bisphosphonate drug</u>?

Yes No 12. Do you take **<u>blood thinners</u>**? If so, please list. ____

<u>Physician List</u> **(Please list your physicians and any medical specialists you see)**

Name	City	Type of Specialty	Phone Number

<u>Dental History</u>

1. What is the reason you are seeking dental treatment? ______________________________________
____

Yes No 2. Do you currently have any dental pain or discomfort? Explain: ___________________________________
____

Yes No 3. Have you had regular dental check-ups?

Yes No 4. Have you had any trouble associated with previous dental treatment? Such as anxiety, fear, allergic reaction. If yes, please explain: ____

I certify that the above information is complete and correct.

Patient or Parent/Guardian Signature____ **Date**_____/______/________

Dentist Signature____ **Date**_______/_______/_______