



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	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Latex	<input type="checkbox"/>	<input type="checkbox"/>	_____		

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	<input type="checkbox"/>	<input type="checkbox"/>	Fragile X Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional defiance disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Facial surgery	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Pervasive developmental disorder	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Fever blisters/cold sores	<input type="checkbox"/>	<input type="checkbox"/>	Pins, Screws, Plates	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum	<input type="checkbox"/>	<input type="checkbox"/>	Hearing disorder	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	High/Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hearth murmur	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Intellectual disability	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disorder	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Alcohol Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder	<input type="checkbox"/>	<input type="checkbox"/>	Visual disorders	<input type="checkbox"/>	<input type="checkbox"/>

Adolescents/Adults (If older than age 12)	Yes	No
	Alcohol Abuse	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>

Females: Adolescent/Adult	Yes	No
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, Number of Weeks: _____		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>

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- Yes No 6. Do you or your pediatrician have any concerns regarding your child's development?
If so, please explain: _____

- Yes No 7. Does your child receive any accommodations, help, or therapies for: behavior, sensory processing, anxiety, speech, etc.? If yes, describe: _____

- Yes No 7. Have you ever been hospitalized or had any surgery? If yes, describe: _____

- Yes No 8. Do you have or ever had any disease, condition, syndrome, or problem not listed here?
If yes, describe: _____

- Yes No 9. Do you have any undiagnosed symptoms? If yes, describe: _____

- Yes No 10. Are you **taking any medication** of any kind? If yes, please list: _____

- Yes No 11. Do you require a **PREMEDICATION/ANTIBIOTIC** prior to any dental treatment? If yes, what medication? _____
- Yes No 12. Have you ever taken any on these medications? If so, please circle.
Fosamax, Actonel, Boniva, Zometa, Atelvia, Reclast, or any other **bisphosphonate drug**?
- Yes No 13. Do you take **blood thinners**? If so, please list. _____

Physician List (Please list your physicians and any medical specialists you see)

Name	City	Type of Specialty	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____

Dental History

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 ____/____/____