Patient Medical History Form

ADA American Dental Association
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For Dental Office Use Only					
Medical Alert Yes - No	Condition Yes - No	Pre-Medication Yes - No	Allergies Yes - No	Anesthesia Yes - No	Date

HEALTH HISTORY FORM

Name: , Home Phone: ( ) - Business Phone: ( ) -
Last First Middle Initial

Address: City: State: Zip Code:
Street Address Required (No P.O. Boxes)

Occupation: Height: ' " Weight: DOB: / / Sex: M F

SS #: - - Emergency Contact: Relationship: Phone Number: ( ) -

If you are completing this form for another person, what is your relationship to that person?
Name Relationship

DENTAL INFORMATION

For the following questions, please ☑ whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

	Yes	No	Don't Know
Do your gums bleed when you brush?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Do you wear removable dental appliances?	☐	☐	☐
Have you had a serious/difficult problem associated with any previous dental treatment?	☐	☐	☐

If yes, explain: _____

How would you describe your current dental problem?

Date of your last dental exam:

Date of your last dental x-rays:

What was done at that time?

How do you feel about the appearance of your teeth?

MEDICAL INFORMATION

If you answer yes to any of the 3 items below, please stop and return this form to the Practice Manager at this time.	Yes	No	Don't Know
❶ Active Tuberculosis.	☐	☐	☐
❷ Persistent cough greater than 3 weeks in duration.	☐	☐	☐
❸ Cough that produces blood.	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
Are you now under the care of a physician?	☐	☐	☐

If yes, what is/are the condition(s) being treated?

_____

Date of last physical examination:

Physician:

( ) -
Name Phone
,

Address: City/State: Zip:

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐

If "yes," what was the illness or problem?

_____

Are you allergic to or have you had a reaction to:

	Yes	No	Don't Know
Local anesthetics	☐	☐	☐

Are you taking or have you recently taken any medicine(s) including non-prescription Medicine?	Yes	No	Don't Know
	☐	☐	☐

If yes, what medicine(s) are you taking?

Prescribed:

Over the counter:

Vitamins, natural or herbal preparations and/or diet supplements:

Have you taken any bone enhancement drugs (bisphosphones; i.e., Fosamax)	☐	☐	☐
Or diet drugs i.e., ; Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination?)	☐	☐	☐
Do you drink alcoholic Beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours?

In the past week?

Are you alcohol and/or drug dependent?	☐	☐	☐

If yes, have you received Treatment? ☐ Yes ☐ No

Do you use drugs or other substances for recreational purposes? ☐ Yes ☐ No

If "yes," please list: _____

Frequency or use: ☐ Daily ☐ Weekly ☐ More Frequently

Number of years of recreational drug use:

Tobacco usage (smoking, snuff, chew?) ☐ Yes ☐ No

If "yes", how interested are you in stopping?
☐ Very ☐ Somewhat ☐ Not Interested

Do you wear contact lenses? ☐ Yes ☐ No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐

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MEDICAL INFORMATION CONTINUED

Are you allergic to or have you had a reaction to:	Yes	No	Don't Know
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food (specify)	☐	☐	☐
Other (specify)	☐	☐	☐
Metals (specify)	☐	☐	☐

Please specify type of reaction to any "yes" answers above:

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If "yes" what antibiotic and dose?	☐	☐	☐

Name of physician or dentist: _____

Phone number of physician/dentist: ( ) -

For Women Only

Are you, or could you be, pregnant?	☐	☐	☐
Are you taking birth control pills or are you on hormonal replacement therapy (HRT)? If "yes:" ☐ Birth Control ☐ HRT	☐	☐	☐

DISEASES AND/OR MEDICAL PROBLEMS

Please ☑ a response to indicate you have or have not had any of the following diseases or medical problems

	Yes	No	Don't Know
Abnormal bleeding	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion. If "yes" date:	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Cardiovascular disease. If "yes" specify below:			
☐ Angina ☐ Heart murmur			
☐ Arteriosclerosis ☐ High blood pressure			
☐ Artificial heart valves ☐ Low blood pressure			
☐ Congenital heart defect ☐ Mitral valve prolapse			
☐ Congestive heart failure ☐ Pacemaker			
☐ Coronary artery disease ☐ Rheumatic heart			
☐ Damaged heart valves ☐ Rheumatic heart disease/ fever			
☐ Heart attack			
☐ Chest pain upon exertion	☐	☐	☐
☐ Chronic pain	☐	☐	☐
Disease, drug or radiation-induced immunosuppression	☐	☐	☐
Diabetes. If "yes" specify: ☐ Type I (insulin dependent) ☐ Type II	☐	☐	☐
Dry mouth	☐	☐	☐
Eating disorder. If "yes" specify:	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/Persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	Don't Know
Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent infections: If "yes" specify:	☐	☐	☐
Kidney problems	☐	☐	☐
Mental health disorders. If "yes" specify:	☐	☐	☐
Malnutrition	☐	☐	☐
Night Sweats	☐	☐	☐
Neurological disorders. If "yes" specify:	☐	☐	☐
Osteopenia or Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Respiratory problems. If "yes" specify: ☐ Emphysema ☐ Bronchitis, etc.	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder, i.e., sleep apnea	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐
Do you have any disease, condition or problem not listed above that you think your dentist should know about? Explain:	☐	☐	☐

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand all the information on this Patient Medical History Form. I acknowledge that my questions, if any, about inquiries set forth herein have been answered to my satisfaction. I will not hold my dentist, or any other member of Robert A. Milner, D.D.S. Dental Corporation, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature _____ Date: _____

FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Date: Comments: Signature Dentist:

Date: Comments: Signature of Patient: