Medical & Dental History

Patient: Family Dr: Print date :

Created on :

Updated on :

Yes No Question

[ ] [ ] 1. Are you currently being treated for any medical condition or have you been treated within the past year? If so, why?

[ ] [ ] 2. When was your last medical checkup?

[ ] [ ] 3. Has there been any change in your general health in the past year? If yes, please explain.

[ ] [ ] 4. Please list medications, drugs and herbal supplements:

[ ] [ ] 5. Do you have any allergies? If yes, please list using the categories below:
A. Medications: _____

B. Latex/Rubber Products: _____

C. Other (eg. hayfever, foods): _____

[ ] [ ] 6. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain

[ ] [ ] 7. Do you have or have you ever had asthma?

[ ] [ ] 8. Do you have or have you ever had any heart or blood pressure problems?

[ ] [ ] 9. Do you have or have you ever had an artificial heart valve, an infection of the heart (ie. infective endocarditis), a heart condition from birth (ie. congenital heart disease) or a heart transplant?

[ ] [ ] 10. Do you have a prosthetic or artificial joint?

[ ] [ ] 11. Do you have any conditions or therapies that could affect your immune system (eg. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?)

[ ] [ ] 12. Have you ever been hospitalized for any illnesses or surgeries? If yes, please explain.

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[ ] [ ] 13. Do you have or have you ever had any of the following? Check those that apply.

[ ] Pacemaker [ ] Drug/alcohol dependency
[ ] Lung Disease [ ] Osteoporosis medications
[ ] Tuberculosis (eg. Fosamax, Actonel)
[ ] Cancer [ ] bleeding problems/disorders [ ] hepatitis, jaundice, liver disease
[ ] Other: _____

[ ] [ ] 14. Do you have or have you ever had any of the following? Check those that apply.

[ ] Chest pain, angina [ ] Steroid therapy
[ ] Heart attack [ ] Diabetes
[ ] Stroke [ ] Stomach ulcers
[ ] Shortness of breath [ ] Arthritis
[ ] Rheumatic fever [ ] Seizures (epilepsy)
[ ] Mitral valve prolapse [ ] Kidney disease
[ ] Heart murmur [ ] Thyroid disease

[ ] [ ] 15. Are there any diseases or medical problems that run in your family? (ie. diabetes, cancer or heart disease?)

[ ] [ ] 16. Do you smoke or chew tobacco products?

[ ] [ ] 17. Are you nervous during dental treatment?

[ ] [ ] 18. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

[ ] [ ] 19. To the best of my knowledge, I consent that the above information is accurate and correct.

Patient/Parent/Guardian Signature: _____

Date: _____

[ ] [ ] 20.

Dentist Signature: _____

Date: _____