

Medical and Dental History

Physician's Name: _____ Date of Last Visit: _____

Please mark a check on "Yes" or "No" to indicate if you have or had any of the following

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression/Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Extractions or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Abnormally	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or Growth On Head or Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, Persistent or Bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Recent Dentist _____ Date of last dental visit _____		Mouth Breathing Mouth Pain Orthodontic TX Pain Around Ear Periodontal TX	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Women ONLY</u>	
Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive - Cold Sensitive - Heat Sensitive - Sweets Sensitive - Biting Sores/Growths in Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you taking birth control? Are you pregnant? Due Date _____
Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you Brush? _____x daily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips/mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you floss? _____x daily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____ _____ _____	
Burning Sensation on Tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Food Collection Between Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Foreign Objects	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Grinding Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Gums Swollen/Tender	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Jaw Pain/Tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Lip/Cheek Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Loose Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Broken Fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No				

NOTE: Both Doctor and patient are encouraged to discuss and all relevant patient health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, 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 of Patient/Legal Guardian Date _____

FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history: _____

Significant finding from questionnaire or oral interview: _____

Dental management: _____

_____ Dr. Initials _____ RDH Initials