Medical Dental History Form

Name: _____ Date: _____

Name of Drug	Strength MG	Frequency Taken	Medication Taken for?

Allergies to Medications	
Name of the Drug	Reaction you had

Latex Allergy _____ Yes _____ No

Past and Current Medical Conditions: Mark all that apply

	Yes		Yes		Yes
Under Physicians' care		Heart trouble		Rheumatic Fever	
Hospitalization? Operations in last 5 years Details:		Heart Surgery: Explain		High Blood Pressure	
		Stroke			
		Artificial Heart Valves		Artificial Joint	
Women Pregnant Due Date: _____		Anemia		Pre-medication needed prior to dental treatment	
Diabetes: Type Controlled by:		Tobacco Use: Type:_____Amount:_____ If quit, What Year: _____		Lung disease	
				Leukemia	
Emphysema/ COPD		Shortness of Breath		Sleep Apnea C-Pap	
Sinus Trouble		Kidney Disease		Cancer Type:_____ Date: _____	
Dialysis		Chemotherapy Date:_____		Eating Disorder	
Radiation Treatment to Head/Neck		Autoimmune disease: Lupus, Pemphigus		Asthma Inhaler?	
Stomach Trouble Reflux, Ulcer, GERD		Head/neck/mouth Injuries		Glaucoma	
Arthritis or joint disorder		Headaches		Neurologic disease	
Fainting / Dizziness		AIDS/HIV Positive		Thyroid Disorder	
Depression/Anxiety		Other psychiatric disorders		Convulsions/ Epilepsy/ seizures	
Cerebral palsy		Alcohol or chemical dependency		Blood Thinners	

Mark all that apply: Dental Health

	Yes		Yes
Mouth odors/bad taste		Dry mouth / excessive	
History of Perio Treatment / Root Planing		Treatment for tempormandibular disorder (TMJ or TMD) Clenching /grinding/popping/clicking/pain	
Sensitive teeth? Hot, cold, pressure or sweets		Cold sores/blisters/oral lesions/ Aphtous ulcers Herpes	
Are you aware of any lumps or swellings		How many soft drinks do you drink a day	
Sore bleeding gums		Family history of extensive decay	
One or more filling in the last 3 years		Have you had oral surgery, Wisdom or other teeth extracted?	
Have you had orthodontics (braces)?		Do you wear a denture or partial denture	
Flossing _____X Daily		Have you had any dental implants placed	
Brushing _____X Daily Electric_____ Manual_____		Snore / Sleep Apnea	
Primary sources of drinking water: **Please circle:** City Water At home Filtration Well Water Bottled Water		**Fluoride:** Water: _____ Toothpaste:_____ **Prescription** Fluoride:_____ Paste:_____ Rinse:_____	

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