

# MEDICAL HISTORY FORM

Date \_\_\_\_\_

## Patient Information:

Patient's Name: \_\_\_\_\_  
Last First Middle InitialAddress: \_\_\_\_\_  
Address City State Zip Code

Email Address: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Sex:  M  F Home No: \_\_\_\_\_ Cell No: \_\_\_\_\_ Alt. No: \_\_\_\_\_

## Parent/Guardian Insurance Information: Relationship to Patient: \_\_\_\_\_ SELF

Name: \_\_\_\_\_  
Last First Middle Initial

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insurance No.: \_\_\_\_\_ Driver License No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Insurance Telephone No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Home No: \_\_\_\_\_ Cell No: \_\_\_\_\_ Work No: \_\_\_\_\_

Name and Number of nearest relative not living with you: \_\_\_\_\_

## How did you hear about us? Please mark below:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Online            | <input type="checkbox"/> Flyer / Mail                    | <input type="checkbox"/> Printed Ad            | <input type="checkbox"/> Billboard               |
| <input type="checkbox"/> Radio             | <input type="checkbox"/> TV                              | <input type="checkbox"/> Community Event       | <input type="checkbox"/> Health Fair / Screening |
| <input type="checkbox"/> Dr. Referral      | <input type="checkbox"/> Driving / Walking by the Office | <input type="checkbox"/> Medicaid              | <input type="checkbox"/> Insurance / Employer    |
| <input type="checkbox"/> Friend / Relative | <input type="checkbox"/> Employee                        | <input type="checkbox"/> Other (Specify) _____ |  |

Reason for today's dental visit: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_

Have you ever had an experience in a dental office that you would like to tell us about?  Yes  No

Please explain if yes: \_\_\_\_\_

Are you nervous about dental treatment?  Yes  No  
Do your gums bleed, feel tender or irritated?  Yes  No  
Are you unhappy with appearance of your teeth?  Yes  NoAre your teeth sensitive?  Yes  No  
Do you have discolored teeth that bother you?  Yes  NoIf yes, to what?  Sweets  Hot  Cold  PressureAre you now seeing a physician?  Yes  No The name & telephone number of your physician(s) \_\_\_\_\_

If so, what is the condition being treated? \_\_\_\_\_

Are you taking any medications?  Yes  No If yes, please list: \_\_\_\_\_Have you or are you currently taking Aspirin?  Yes  NoIf female, are you or do you suspect to be pregnant?  Yes  No Months: \_\_\_\_\_Have you or are you currently taking oral Bisphosphates?  Actonel  Boniva  Fosamax  Skelif  Didrone  Other \_\_\_\_\_Have you had any joint replacements?  Yes  No If yes, when? \_\_\_\_\_Is there anything else we should know about your health that was not covered on this form?  Yes  No

If yes, Please explain: \_\_\_\_\_

## Please mark any of the following which you have had or have at present:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Nervousness               | <input type="checkbox"/> NONE                |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Kidney Trouble       | <input type="checkbox"/> Thyroid Disease           | <input type="checkbox"/> HIV + AIDS          |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bone Loss            | <input type="checkbox"/> Chemo: (Cancer, Leukemia) | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Hemophilia          |
| <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Rheumatism                | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Bruise Easily       |
| <input type="checkbox"/> Heart Pacemaker     | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Joint Replacement         | <input type="checkbox"/> Pain in Jaw Joint   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Scarlet Fever        | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Diabetes            |
|  |   |  | <input type="checkbox"/> Glaucoma            |

## Please mark any of the following medical allergies:

- |  |  |   |                                       |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Penicillin        | <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> NONE         |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Other antibiotic: | <input type="checkbox"/> Barbiturates or sedatives  | <input type="checkbox"/> Fen-Phen     |
| <input type="checkbox"/> Iodine            | <input type="checkbox"/> Sulfa Drugs       | <input type="checkbox"/> Latex                      | <input type="checkbox"/> Other: _____ |
|  |  |   | <input type="checkbox"/> Other: _____ |

**To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change, I will inform my dentist at the next appointment.**

\_\_\_\_\_  
Signature of Patient/Parent/Guardian\_\_\_\_\_  
Medical History Update:

Dr. \_\_\_\_\_ Date \_\_\_\_\_

Dr. \_\_\_\_\_ Date \_\_\_\_\_

Dr. \_\_\_\_\_ Date \_\_\_\_\_