Dental Hygiene Clinic

Medical/Dental History Form

NAME: _____ **HOME PHONE:** _____ **WORK PHONE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

OCCUPATION: _____ **DATE OF BIRTH:** _____ **SEX: M** ☐ ____ **F** ☐

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP TO THAT PERSON?

NAME: _____ **RELATIONSHIP** _____

DENTAL INFORMATION:

How would you describe your current dental problem?_____

Date of last dental exam:_____ Date/Type of Last Dental X-rays:_____

Dentist:_____Dentist Phone:_____

Circle Yes or No:

DO YOUR GUMS BLEED WHEN YOU BRUSH?	YES	NO
ARE YOUR TEETH SENSITIVE?	YES	NO
ARE YOUR GUMS SHRINKING AWAY FROM YOUR TEETH?	YES	NO
DO YOU WEAR REMOVABLE DENTAL APPLIANCES?	YES	NO
HAVE YOU HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT?	YES	NO

HAVE YOU HAD SIDE EFFECTS ASSOCIATED WITH DENTAL INJECTIONS?	YES	NO
ARE YOUR JAWS TIRED AT THE END OF THE DAY?	YES	NO
DO YOU GRIND/CLINCH YOUR TEETH?	YES	NO
DO YOU GET "COLD SORES"?	YES	NO
HAS A DENTIST OR PHYSICIAN RECOMMENDED THAT YOU TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT?	YES	NO

IF YES, WHAT ANTIBIOTIC AND DOSE?_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

ORTHODONTICS	YES	NO	_____	ENDODONTICS	YES	NO	_____
TMJ THERAPY	YES	NO	_____	ORAL SURGERY	YES	NO	_____
EXTRACTIONS	YES	NO	_____	ORAL CANCER	YES	NO	_____
PERIODONTAL THERAPY	YES	NO	_____	DENTAL IMPLANTS	YES	NO	_____

MEDICAL INFORMATION:

ARE YOU IN GOOD HEALTH? YES NO

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR? YES NO

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO IF YES, WHY?_____

DATE OF LAST PHYSICAL EXAM?_____

PHYSICIAN:_____PHONE:_____

CITY/STATE/ZIP:_____

VITAL SIGNS: TO BE COMPLETED BY CLINICIAN			
BP / /	RESP:	PULSE:	TEMP:
DESCRIPTION:			

MEDICAL INFORMATION – CONTINUED

HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION OR HAVE BEEN HOSPITALIZED IN THE LAST 5 YEARS? IF YES – WHAT WAS THE PROBLEM:_____ YES NO
_____

ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN ANY MEDICINE INCLUDING NON-PRESCRIPTION MEDICATION? IF YES, WHAT MEDICATION ARE YOU TAKING?_____ YES NO
_____
_____
_____

ARE YOU TAKING OR HAVE YOU TAKEN ANY DIET DRUGS? YES NO

DO YOU DRINK ALCOHOLIC BEVERAGES YES NO
IF YES – HOW MUCH ALCOHOL DO YOU DRINK ?_____

DO YOU USE DRUGS OR OTHER SUBSTANCES FOR RECREATIONAL PURPOSES? YES NO
IF YES, PLEASE LIST:_____
_____
_____

DO YOU USE TOBACCO YES NO
IF YES, PLEASE LIST, WITH FREQUENCY FOR AND FOR HOW LONG:_____

IF YOU DO USE TOBACCO, HOW INTERESTED ARE YOU IN STOPPING: CIRCLE ONE: VERY SOMEWHAT NOT

DO YOU WEAR CONTACT LENSES? YES NO

DO YOU HAVE ANY ALLERGIES? YES NO
IF YES, TO WHAT:_____
_____
_____

HAVE YOU EVER BEEN TOLD NOT TO TAKE ANY MEDICATIONS? IF YES, WHAT: YES NO
_____
_____
_____

PATIENT/GUARDAN SIGNATURE AND DATE:

_____

FOR THE FOLLOWING DISEASES/PROBLEMS, PLEASE CIRCLE YES OR NO:

ABNORMAL BLEEDING	YES	NO
AIDS OR HIV INFECTION	YES	NO
ANEMIA	YES	NO
ARTHRITIS	YES	NO
RHEUMATOID ARTHRITIS	YES	NO
ASTHMA	YES	NO
BLOOD TRANSFUSION	YES	NO
CANCER/CHEMO/RADIATION	YES	NO
CARDIOVASCULAR DISEASES	YES	NO

_____ANGINA
_____ARTERIOSCLEROSIS
_____ARTIFICIAL HEART VALVE
_____CONGENITAL HEART DEFECTS
_____CONGESTIVE HEART FAILURE
_____CORONARY ARTERY DISEASE
_____DAMAGED HEART VALVES
_____HEART ATTACK
_____HEART MURMUR
_____HIGH BLOOD PRESSURE
_____LOW BLOOD PRESSURE
_____MITRAL VALVE PROLAPSE
_____PACE MAKER
_____RHEUMATIC HEART DISEASE/FEVER

DIABETES	YES	NO
DRY MOUTH	YES	NO
EATING DISORDER	YES	NO
EPILEPSY	YES	NO
FAINTING SPELLS/SEIZURES	YES	NO
GASTROINTESTINAL DISEASE	YES	NO
GLAUCOMA	YES	NO
HEPATITIS/LIVER DISEASE	YES	NO
JOINT REPLACEMENT	YES	NO
KIDNEY PROBLEMS	YES	NO
MENTAL HEALTH DISORDERS	YES	NO
NIGHT SWEATS	YES	NO
OSTEOPOROSIS	YES	NO
RESPIRATORY PROBLEMS	YES	NO
SEVERE HEADACHES/MIGRAINES	YES	NO
SEXUALLY TRANSMITTED DISEASE	YES	NO
SLEEP DISORDER	YES	NO
STROKE	YES	NO
TUBERCULOSIS	YES	NO
THYROID PROBLEMS	YES	NO
ULCERS	YES	NO
EXCESSIVE URINATION	YES	NO

WOMEN ONLY:
ARE YOU OR COULD YOU BE PREGNANT? YES NO

SUPERVISING DENTIST SIGNATURE AND DATE:

_____