MEDICAL DENTAL HISTORY FORM

Patient Name:_____ Medical Clinic_____

Patient ID #: _____ Physician_____

Allergies to: **PreMed required?** Yes No

Latex: Yes No

Medications _____ Reason: _____

Other _____ Type: _____ Dosage:

Current Medications (Prescription, Over the counter and Herbal)

MEDICATION		DOSAGE		FREQUENCY		MEDICATION		DOSAGE		FREQUENCY	

PAST AND CURRENT MEDICAL CONDITIONS (mark all that apply)

	Yes		Yes
8 Under physician's care?		37 Sinus trouble?	
Details:		38 Cancer? Year Diagnosed:	
9 Hospitalization/operation(s) in last 5 years?		39 Oral Cancer? Year Diagnosed:	
Details:		40 Family History of Head/Neck Cancer?	
10 Head/neck/mouth injuries?		41 Radiation Treatment to Head/Neck?	
11 Women: pregnant?		42 Chemotherapy?	
12 Women: nursing?		43 Kidney Disease?	
13 Women: oral contraceptives?		44 Dialysis?	
14 Heart trouble/disease?		45 Eating Disorder?	
15 Rheumatic fever?		46 Stomach: reflux? ulcer?	
16 Past use of Fenphen?		47 Immunological disease?	
17 Heart murmur?		48 Sjogrens Disease?	
18 Mitral valve prolapse?		49 Fibromylagia?	
19 Heart surgery?		50 Other autoimmune disease (lupus, pemphigus)?	
20 Artificial heart valves?		51 Arthritis or other joint disorders?	
21 Pacemaker?		52 Diabetes? Type: Controlled? Y N	
22 Indwelling defibrillator?		53 Headaches?	
23 Artificial joints?		54 Depression: Diagnosed?	
24 History of Organ Transplant?		55 Other Psychiatric Disorders?	
25 High blood pressure? BP: /		56 Neurologic Disease?	
26 Stroke?		57 Convulsions?	
27 Bleeding problem?		58 Epilepsy/seizures?	
28 Hemophilia?		59 Cerebral Palsy?	
29 Anemia?		60 Fainting/dizziness?	
30 Leukemia?		61 Sexually Transmitted Disease (STD)?	
31 Lung disease?		62 History of Human Papilloma Virus 16 or 18	
32 Emphysema?		63 AIDS/HIV positive?	
33 Shortness of Breath?		64 Alcohol or chemical dependency?	
34 Asthma?		65 Hepatitis?	
35 Sleep Apnea?		66 Thyroid disease?	
36 Tuberculosis?		67 Glaucoma?	

	Yes
68 Alcohol use? Amount per week: How long:	
69 Former tobacco user? Type: Year quit: Quit for how long:	
70 Tobacco user? Type: Amount:	
71 How soon after wake up do you use tobacco? within 5 min 6-30 min 31-60 min over 60 min	
72 Previous attempts to quit	
73 Are you interested in quitting tobacco?	

DENTAL INFORMATION:

74 Previous dentist:
75 Last dental visit:
76 Last dental cleaning
77 Frequency of dental exams
78 What made you decide to make this dentist appointment?
79 Frequency of brushing:
80 Frequency of flossing:
81 What are some typical foods you eat between meals?
82 What types of beverages do you typically drink between meals?
83 How often do you chew or suck on hard candy, cough drops or mints?
84 Do you use fluoridated toothpaste? Yes
85 Primary source of drinking water? (circle) City water filtered City water unfiltered Bottled water Well water

PAST DENTAL TREATMENT:

	Yes
86 One or more fillings in the last three years?	
87 Family history of extensive decay?	
88 If Child, mother's history of decay?	
89 Treatment for periodontal (gum) disease?	
90 Family history of periodontal disease?	
91 Have you had orthodontics (braces)?	
92 Have you had oral surgery?	
93 Have you had any dental implants placed?	
94Treatment for tempormandibular disorders?	
95 Do you wear a denture(s) or partial denture(s)?	

DO YOU HAVE CONSISTENT PROBLEMS WITH:

96 Dry mouth/excessive thirst	
97 Sensitive teeth? Hot Cold Pressure Sweets	
98 Mouth odors/bad taste?	
99 Cold sores/blisters/oral lesions?	
100 Are you aware of any swelling or lumps?	
101 Sore, bleeding gums?	
102 Loose teeth?	
103 Difficulty chewing?	
104 Food catches between teeth?	
105 Teeth/filling break frequently?	
106 Clenching or grinding habits?	
107 Do you hear popping, clicking or snapping?	
108 Do you have jaw pain?	
109 Are you nervous about dental work?	