



Staff Initials: \_\_\_\_\_

# DENTAL ■ PATIENT MEDICAL HISTORY FORM

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer these questions as best you can, so we can give you the best care possible. Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know.) Your answers are confidential and for our records only.

### Medical

Yes No DK

Has there been a major change to your health within the past year? .....

If yes, please explain: \_\_\_\_\_

Are you under the care of a physician or are you receiving ongoing medical care? .....

Name of your physician: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

Date of your last medical visit: \_\_\_\_\_

Are you pregnant? .....

If Yes, due date: \_\_\_\_\_

Do you breast feed? .....

Do you have any artificial joints, heart valves, implants, or prosthesis? .....

Have you ever been told you need to be pre-medicated prior to dental treatment? .....

Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition? .....

If yes, please explain: \_\_\_\_\_

### Dental

Yes No DK

Are you having any dental discomfort at this time? .....     
If yes, please explain: \_\_\_\_\_

Have you ever had serious trouble with previous dental work? .....     
If yes, please explain: \_\_\_\_\_

Does dental work make you nervous? .....

Have you ever had any abnormal bleeding associated with previous extractions, surgery, or trauma? .....     
If yes, please explain: \_\_\_\_\_

Date of your last dental visit: \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

### Other:

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know):

Yes No DK

Do you use tobacco? .....    What? \_\_\_\_\_ How much \_\_\_\_\_

Do you use alcohol? .....    What? \_\_\_\_\_ How much \_\_\_\_\_

Do you have any CURRENT/PAST history of substance abuse? ..    If yes, please explain: \_\_\_\_\_

### Medications

Are you taking any prescription or over-the-counter medications?

Yes No DK

Please list all medications you are taking (Please include prescription and non-prescription medications):

Medication:	Dosage:	How Often Taken:	Reason for Medication:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____

### Allergies

Are you allergic to anything?

Yes No DK

Please list all allergies including reaction:

Allergy to:	Reaction:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____



**Medical Information:**

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know).

**Heart and Circulatory Problems**

Yes No DK

- Heart Attack .....
- If yes, when \_\_\_\_\_
- High Blood Pressure.....
- Chest Pain (Angina) .....
- Heart Murmurs.....
- Artificial Valves .....
- Other Heart Problems.....
- Comments \_\_\_\_\_

**Stomach Problems**

Yes No DK

- Stomach Pain .....
- Heartburn.....
- History of Ulcers .....
- Colitis.....
- Comments \_\_\_\_\_

**Neurologic Problems**

Yes No DK

- Epilepsy/Seizures .....
- Chronic Headaches.....
- History of Head Injury.....
- Numbness of Arms, Legs, Hands or Feet.....
- History of Stroke .....
- If yes, when \_\_\_\_\_
- Fainting Spells.....
- Comments \_\_\_\_\_

**Diabetes and Gland Problems**

Yes No DK

- Diabetes - Type I .....
- Diabetes - Type II .....
- Thyroid Problems .....
- Other Gland Problems.....
- Comments \_\_\_\_\_

**Mental Health Problems**

Yes No DK

- Depression .....
- Anxiety.....
- History of Psychiatric Medications .....
- Comments \_\_\_\_\_

**Blood Problems**

Yes No DK

- Bleeding Problems .....
- Anemia .....
- Hemophilia.....
- Are you taking blood thinners?...
- If yes, recent INR level \_\_\_\_\_
- Comments \_\_\_\_\_

**Breathing/Lung Problems**

Yes No DK

- Hay Fever .....
- Shortness of Breath.....
- Persistent Cough.....
- Positive Test/Treatment for Tuberculosis .....
- Seasonal Allergies.....
- Asthma .....
- Emphysema.....
- Coughing up Blood .....
- Comments \_\_\_\_\_

**Muscle and Bone Problems**

Yes No DK

- Joint/Back Pain.....
- History of Broken Bones.....
- Joint Swelling.....
- Arthritis .....
- Comments \_\_\_\_\_

**Other**

Yes No DK

- Domestic Abuse.....
- Immune System Disorders .....
- Venereal Disease .....
- AIDS/HIV .....
- Kidney or Bladder Problems .....
- Frequent Urinary Tract Infections .....
- Comments \_\_\_\_\_

**Skin Problems**

Yes No DK

- Rashes .....
- Mole Changes .....
- Comments \_\_\_\_\_

**Liver**

Yes No DK

- Hepatitis A, B, or C .....
- Alcoholic Liver Disease .....
- Other Liver Disease.....
- Jaundice .....
- Comments \_\_\_\_\_

Do you have any other disease, condition or problem not listed?..

If Yes, please explain \_\_\_\_\_

\_\_\_\_\_

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to Northwind Dental.

**We set aside time just for you. If you're running late or must change an appointment, please call us as soon as possible. Arriving late may require your provider to reschedule your visit to allow enough time for your care. If you miss an appointment, you may have to wait for another opening. If you miss two appointments, you may be only able to make same-day appointments. By calling us when you are unable to make your scheduled appointment, we are able to see other patients waiting for an appointment. These rules are firm so that we can serve everyone in need of care.**

Signature of Patient or Guardian

Date

Date