Dental-Medical History

NAME (LAST, FIRST, MIDDLE)

MAIDEN NAME (IF MARRIED)

ADDRESS (NUMBER AND STREET) (CITY, STATE, ZIP)

HOME PHONE BUSINESS PHONE

DATE OF BIRTH SEX HEIGHT WEIGHT

COUNTRY OF BIRTH

OCCUPATION SOCIAL SECURITY #

SINGLE MARRIED NAME OF SPOUSE

REFERRED BY

PLEASE ANSWER EACH QUESTION

MEDICAL RESPONSE:

	YES	NO
1. Have you been a patient in a hospital during the past 2 years?	☐	☐
For _____		
2. Have you been under the care of a physician during the past 2 years?	☐	☐
For _____		
3. Have you taken any kind of medicine or drugs during the past year?	☐	☐
Name of drug _____		
4. Have you been out of the United States?	☐	☐
Where _____ When _____		
5. Are you allergic to penicillin or any drugs or medicine?	☐	☐
6. Have you ever had any excessive bleeding requiring special treatment?	☐	☐
7. Have you had prolonged coughing or coughed up blood?	☐	☐
8. Have you ever had a blood test for hepatitis?	☐	☐
9. If so, were you vaccinated?	☐	☐
10. Have you had cankers or cold sores on your lips, tongue, gums or body?	☐	☐

11. Circle any of the following which you have had or now have:

AIDS	artificial heart valves	congenital heart lesions	heart murmur	high blood pressure	sinus trouble
allergies	asthma	cough	heart trouble	jaundice	stroke
anemia	cancer treatment	diabetes	hepatitis	kidney treatment	tuberculosis
arthritis	cardiac pacemaker	epilepsy	herpes	psychiatric treatment	

12. Have you had any other serious illnesses?	☐	☐
13. If female, are you pregnant now?	☐	☐
14. If female, are you nursing?	☐	☐

DENTAL RESPONSE:

1. Do you brush your teeth daily?	☐	☐
2. Do you have a swelling in the roof of your mouth?	☐	☐
3. Have you noticed purplish color on your gums or cheek?	☐	☐
4. Do your gums bleed sometimes?	☐	☐
5. Are your teeth painful?	☐	☐
6. Can you chew well on both sides of your mouth?	☐	☐

List main dental complaint(s): _____

TO BE ANSWERED ONLY BY PATIENTS RECEIVING SEDATION OR GENERAL ANESTHESIA:

1. Have you had anything to eat or drink within the last 4 hours?	☐	☐
2. Are you wearing removable dental appliances?	☐	☐
3. Are you wearing contact lenses?	☐	☐
4. Do you have someone to drive you home today?	☐	☐

Name _____

Signature Date