



**Medical/Dental History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First, Middle

Who was your previous dentist? \_\_\_\_\_

When was the last time you had dental x-rays taken? \_\_\_\_\_

Have you ever had a major operation?  Yes  No Describe: \_\_\_\_\_

Have you ever had a head or neck injury?  Yes  No Describe: \_\_\_\_\_

Are you taking any medication now?  Yes  No Describe: \_\_\_\_\_

Do you smoke or chew tobacco products?  Yes  No If yes, how often: \_\_\_\_\_

Is your general health good?  Yes  No If no, describe: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Are you allergic to any of the following?**

|              |  |          |  |              |  |
|--------------|--|----------|--|--------------|--|
| Aspirin      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Acrylic  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin   | <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| Metal        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Earrings | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foods        | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Which: _____ |
| Latex Rubber | <input type="checkbox"/> Yes <input type="checkbox"/> No | Codeine  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No                 |

**Do you have or have you had any of the following?**

|                       |  |                      |  |                   |  |
|-----------------------|--|----------------------|--|-------------------|--|
| Artificial Limb       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leaky Heart Valve    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Irregular Heart Beat  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Convulsions          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatoid Arthritis  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Circulation Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocarditis      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Problems     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A,B, or C  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

# Dental Health Wellness Center

|                    |  |                |  |                   |  |
|--------------------|--|----------------|--|-------------------|--|
| Hemophilia         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rx Diet Pills  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis (TB)  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy       | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Digestive Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | General Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes       | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS              | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you ever had any serious illness not checked above? If yes, describe: \_\_\_\_\_

### For Women Only

|                   |  |                                     |  |
|-------------------|--|-------------------------------------|--|
| Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you trying to get pregnant?     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you nursing?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you taking oral contraceptives? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and/or staff at the next appointment without fail. I hereby authorize the dental office to administer such medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. Notice of privacy practices (you may refuse to sign this acknowledgement): I have read the posted Notice of Privacy Practices and agree to this policy. I also grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals and may be used and disclosed for treatment, payment, or healthcare operations (PHI).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_