



# Medical Dental History Form

Name \_\_\_\_\_ Address \_\_\_\_\_  
 Phone \_\_\_\_\_ DOB \_\_\_\_\_ Spouse \_\_\_\_\_  
 Employer \_\_\_\_\_ Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
 Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Date of Last Physical Exam \_\_\_\_\_ Date of Last Dental Exam \_\_\_\_\_

**DO YOU, OR HAVE YOU EVER, HAD ANY OF THE FOLLOWING?**

	YES	NO	UNKNOWN	COMMENTS
Any breathing or respiratory problems?.....	[ ]	[ ]	[ ]	_____
Asthma? (If yes answer a,b).....	[ ]	[ ]	[ ]	_____
a) If yes are you steroid dependent?.....	[ ]	[ ]	[ ]	_____
b) Do you use an inhaler?.....	[ ]	[ ]	[ ]	_____
Sinus Problems?.....	[ ]	[ ]	[ ]	_____
Seasonal allergies or hayfever?.....	[ ]	[ ]	[ ]	_____
Airway obstructions?.....	[ ]	[ ]	[ ]	_____
Difficulty with intubation during general anesthesia?.....	[ ]	[ ]	[ ]	_____
A smoking habit ?.....	[ ]	[ ]	[ ]	_____
History of TB?.....	[ ]	[ ]	[ ]	_____
High blood pressure?.....	[ ]	[ ]	[ ]	_____
Low blood pressure?.....	[ ]	[ ]	[ ]	_____
Angina?.....	[ ]	[ ]	[ ]	_____
Heart Attack?.....	[ ]	[ ]	[ ]	_____
Stroke?.....	[ ]	[ ]	[ ]	_____
Coronary Artery disease?.....	[ ]	[ ]	[ ]	_____
Arrhythmias?.....	[ ]	[ ]	[ ]	_____
Rheumatic Fever.....	[ ]	[ ]	[ ]	_____
Heart murmur?.....	[ ]	[ ]	[ ]	_____
Inborn heart defects?.....	[ ]	[ ]	[ ]	_____
Mitral Valve prolapse?.....	[ ]	[ ]	[ ]	_____
Artificial Heart Valves?.....	[ ]	[ ]	[ ]	_____
Pacemaker? ( If yes, answer a).....	[ ]	[ ]	[ ]	_____
a) Should electronic devices be avoided? .....	[ ]	[ ]	[ ]	_____
Heart Surgery?.....	[ ]	[ ]	[ ]	_____
Do you require antibiotics before dental treatment?.....	[ ]	[ ]	[ ]	_____
Blood dyscrasias?.....	[ ]	[ ]	[ ]	_____
Sickle Cell anemia?.....	[ ]	[ ]	[ ]	_____
Thyroid problems?.....	[ ]	[ ]	[ ]	_____
Diabetes? (If yes answer a-c).....	[ ]	[ ]	[ ]	_____
a) If diabetic are you on insulin?.....	[ ]	[ ]	[ ]	_____
b) If diabetic are you well controlled?.....	[ ]	[ ]	[ ]	_____
c) If diabetic are you on oral medications?.....	[ ]	[ ]	[ ]	_____
Liver Disease?.....	[ ]	[ ]	[ ]	_____
Hepatitis A ?.....	[ ]	[ ]	[ ]	_____
Hepatitis B ?.....	[ ]	[ ]	[ ]	_____
Hepatitis C ?.....	[ ]	[ ]	[ ]	_____
Stomach or duodenal ulcer?.....	[ ]	[ ]	[ ]	_____
GERD (Gastro Esophageal Reflux Disease).....	[ ]	[ ]	[ ]	_____
Colitis ?.....	[ ]	[ ]	[ ]	_____
Kidney disease?.....	[ ]	[ ]	[ ]	_____
Kidney stones ?.....	[ ]	[ ]	[ ]	_____
Glaucoma ?.....	[ ]	[ ]	[ ]	_____

	YES	NO	UNKNOWN	COMMENTS
Cancer ? (If yes please answer a-d).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
a) What type of cancer did you have?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) Chemotherapy ?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) Radiation ?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
d) Other treatment for cancer ?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Facial or Jaw trauma?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone, joint or muscular problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Artificial joints or surgically placed prosthesis?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis ?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, how long?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any problems with local anesthesia ?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting with local anesthesia?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy to local anesthesia ? If so, what happened?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty getting numb ?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of paresthesia ?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Disorders?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental or emotional problems ?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol or substance abuse?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Dental</b>				
Are you experiencing pain from your mouth at this time?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do your gums bleed? When?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever has an acute sore mouth or "trench" mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you aware of a bad taste or odor in your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you troubled with frequent "gum boils"?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold Sores?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Herpes?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Xerostomia (dry mouth)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did either your mother, father, brother or sister lose all their natural teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you satisfied with the appearance of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a severe toothache?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you bothered by tooth sensitivity? Hot, cold, sweets?..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does food catch between your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do tartar and stain return quickly?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do cavities develop rapidly?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Can you chew satisfactorily?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you chew on both sides of your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any particular mouth habits? Lip, cheek or tongue biting, foreign objects between teeth, etc.?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you conscious of any habit with your tongue?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you awaken in the morning with your teeth together, tired jaws, numb feeling in your teeth or pain in your jaw?..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do your teeth come together evenly?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you conscious of sore, loose or shifting teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you conscious of any high or rough teeth or fillings?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you ever have pain opening or closing your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your jaw ever go, "out of joint"?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had any teeth removed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have the missing tooth or teeth replaced?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	UNKNOWN	COMMENTS
<b>Allergies</b>				
Allergy to latex ?.....	[ ]	[ ]	[ ]	_____
Allergy to nickel, acrylic or other ?.....	[ ]	[ ]	[ ]	_____
Allergic to any medications or foods? (If yes please list)...	[ ]	[ ]	[ ]	_____

**Female Patients only:**

Pregnant ?.....	[ ]	[ ]	[ ]	_____
Taking birth control pills?.....	[ ]	[ ]	[ ]	_____
HIV positive?.....	[ ]	[ ]	[ ]	_____
Have you had any infections in the last 2 weeks?.....	[ ]	[ ]	[ ]	_____
Do you have any medical problems not mentioned above? (Please list).....	[ ]	[ ]	[ ]	_____

**Please list all prescription and non-prescription medications, and herbal products that you are presently taking:**

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Have there been any medications that you have had to stop because you experienced side effects?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**TO BE COMPLETED BY DENTIST:**

**Dental Implications Regarding Medication / Dental History:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do any of the above medications effect the QT interval?**

\_\_\_\_\_

\_\_\_\_\_

**Dentist's Signature** \_\_\_\_\_

**Name (printed)** \_\_\_\_\_ **Date** \_\_\_\_\_

**For Use by DMD (notes)**

**Patient's Signature** \_\_\_\_\_

\_\_\_\_\_