Medical
Alert
Sticker

MEDICAL–DENTAL HISTORY

Patient's Name DOB / / SSN

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

MEDICAL HISTORY

* Write the answer to each question in the space provided.
* If the question is not understood, you are not certain of the answer, or have any question, indicate so in the space, and discuss the matter with the doctor.
* All questions must be answered.
* Use black ink or ball point pen.

Name of Physician ______ Phone ______

Address ______

Date of Last Visit ______ Reason For Last Visit ______

1. Are you currently under the care of a physician? If yes, for what reason or condition? ______

2. Are you currently taking any medication? If yes, what medication and for what reason or condition?

Have You Ever Had Or Been Treated For:

3. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? ______

4. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? ______

5. Stomach or intestinal disease? ______

6. Abnormal blood pressure, excessive bleeding, or anemia? ______

7. Breathing problems, asthma, tuberculosis, or hay fever? ______

8. Cancer, X-ray treatments, or chemotherapy? ______

9. Diabetes? ______

10. Hepatitis, jaundice, or liver disease? ______

11. Kidney problems or renal dialysis? ______

12. Venereal disease or AIDS? ______

13. A stroke, convulsions, or fainting spells? ______________________

14. Tumors or growths? ______________________

15. Arthritis or rheumatism? ______________________

16. Allergic reactions to medications? ______________________

17. Have you ever had a major operation? If yes, describe. ______________________

18. Have you ever had a serious injury to your head or neck? If yes, describe. ______________________

19. Are you on a special diet? If yes, for what reason and describe. ______________________

20. Do you smoke? If yes, describe type and quantity. ______________________

21. Have you consulted or been treated by a psychiatrist, psychologist or counsellor? If yes, describe. ______________________

22. Are there any other problems about your health of which you are aware? ______________________

23. For women: are you pregnant? ______________________

DENTAL HISTORY

Date of your last visit to a dentist ______________________

Reason for your last visit (or series of visits) ______________________

Do you have any of your X-rays or dental records? ______________________

In respect to any previous dental treatment have you:

24. Ever fainted? ______________________

25. Had an allergic reaction? ______________________

26. Had abnormal bleeding? ______________________

27. Any other complications during or following dental treatment? If yes, describe. ______________________

28. Do your gums bleed on brushing or eating? ______________________

29. Does food catch between your teeth? ______________________

30. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? ______________________

31. Are any of your teeth sensitive to heat, cold, or pressure? ______

32. Do you grind your teeth or clench your jaws? ______

33. Do you have pain or clicking in the jaw joint around your ear? ______

34. Have your jaw muscles ever been sore? If yes, describe. ______

35. Are there any sores or growths in your mouth? ______

36. Do any of your teeth ache? ______

37. Do you have any other dental complaint? ______

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or other health practitioners.

Person completing the form: Signature ______

Print Name: ______

If other than patient, indicate relationship: ______ Date ___/___/___

Dentist's History Review & Significant Findings

______

Signature Dr. ______ Date ______