Hometown Family Dental medical history form

Patient Name: Birth Date: Date Created:

Dental information

NO to all

Please indicate if any of the following does or does not apply to you:

Gums bleed when brushing or flossing	○ Yes ○ No	Teeth sensitive to temperature, sweets a	○ Yes ○ No	Dry mouth	○ Yes ○ No
Orthodontic treatment (braces)	○ Yes ○ No	Periodontal (gum) treatment	○ Yes ○ No	Problems with previous dental treatment	○ Yes ○ No
Fluoridated water at home	○ Yes ○ No	Drink bottled water	○ Yes ○ No	Pain in jaw joints	○ Yes ○ No

Are you currently experiencing dental pain or discomfort? ○ Yes ○ No If yes

What is the reason for your dental visit today? Comment

How do you feel about your smile? Comment

Medical information

NO to all

Are you under a physician's care now? ○ Yes ○ No If yes

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes

Are you taking any prescription medications, pills, or drugs? ○ Yes ○ No If yes

Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing biophosphonates? ○ Yes ○ No If yes

Are you on a special diet? ○ Yes ○ No If yes

Do you use tobacco? ○ Yes ○ No If yes

Do you use controlled substances? ○ Yes ○ No If yes

Women's health

NO to all

Women, are you:

Pregnant/trying to get pregnant?	○ Yes ○ No	Nursing?	○ Yes ○ No	Taking oral contraceptives?	○ Yes ○ No

Allergies

NO to all

Are you allergic to any of the following?

Aspirin	○ Yes ○ No	Penicillin	○ Yes ○ No	Codeine	○ Yes ○ No	Acrylic	○ Yes ○ No
Metal	○ Yes ○ No	Latex	○ Yes ○ No	Sulfa drugs	○ Yes ○ No	Local anesthetics	○ Yes ○ No

Do you have any other allergies? ○ Yes ○ No If yes

Health conditions

NO to all

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	○ Yes	○ No	Alzheimer's disease	○ Yes	○ No	Anaphylaxis	○ Yes	○ No	Anemia	○ Yes	○ No
Angina	○ Yes	○ No	Arthritis/gout	○ Yes	○ No	Artificial joint	○ Yes	○ No	Asthma	○ Yes	○ No
Blood disease	○ Yes	○ No	Blood transfusion	○ Yes	○ No	Cancer	○ Yes	○ No	Chemotherapy	○ Yes	○ No
Chest pains	○ Yes	○ No	Cold sores/fever blisters	○ Yes	○ No	Convulsions	○ Yes	○ No	Cortisone medicine	○ Yes	○ No
Diabetes	○ Yes	○ No	Drug addiction	○ Yes	○ No	Emphysema and/or COPD	○ Yes	○ No	Epilepsy or seizures	○ Yes	○ No
Excessive bleeding	○ Yes	○ No	Fainting spells/dizziness	○ Yes	○ No	Frequent cough	○ Yes	○ No	Genital herpes	○ Yes	○ No
Hay fever	○ Yes	○ No	Heart attack/failure	○ Yes	○ No	Heart murmur	○ Yes	○ No	Heart pacemaker	○ Yes	○ No
Heart trouble/disease	○ Yes	○ No	Hemophilia	○ Yes	○ No	Hepatitis A, B, or C	○ Yes	○ No	Herpes	○ Yes	○ No
High or low blood pressure	○ Yes	○ No	High cholesterol	○ Yes	○ No	Hypoglycemia	○ Yes	○ No	Irregular heartbeat	○ Yes	○ No
Kidney problems	○ Yes	○ No	Leukemia	○ Yes	○ No	Liver disease	○ Yes	○ No	Lung disease	○ Yes	○ No
Mitral valve prolapse	○ Yes	○ No	Osteoporosis	○ Yes	○ No	Parathyroid disease	○ Yes	○ No	Psychiatric care	○ Yes	○ No
Radiation treatments	○ Yes	○ No	Rheumatic fever	○ Yes	○ No	Rheumatism	○ Yes	○ No	Sickle cell disease	○ Yes	○ No
Sinus trouble	○ Yes	○ No	Spina bifida	○ Yes	○ No	Stomach/intestinal disease	○ Yes	○ No	Stroke	○ Yes	○ No
Swelling of limbs	○ Yes	○ No	Thyroid disease	○ Yes	○ No	Tonsilitis	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Tumors or growths	○ Yes	○ No	Yellow jaundice	○ Yes	○ No						

Have you ever had any serious illness not mentioned above? ○ Yes ○ No If yes

Do you have a cough that produces blood? ○ Yes ○ No If yes

Have you been exposed to anyone with tuberculosis? ○ Yes ○ No

Have you had or do you currently have any of the following heart-related conditions?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Artificial (prosthetic) heart valve?	○ Yes	○ No	Infective endocarditis	○ Yes	○ No	Heart transplant	○ Yes	○ No
Congenital heart disease	○ Yes	○ No	Unrepaired, cyanotic congenital heart di	○ Yes	○ No	Repaired congenital heart disease	○ Yes	○ No

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? ○ Yes ○ No If yes

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:____________