## Dental Clinic Medical History

Patient Name:__________________________________ Date of Birth:_______________ Sex: M F Other
*If completed by other than patient please provide name and relationship___________________/____________________

Main Dental Complaint:

**Medical Questions**

| | Yes | No |
|---|---|---|
| Are you having any dental pain? .......................................... | ☐ | ☐ |
| If so, how severe 1-10 (10 being the worst) ......... **1 2 3 4 5 6 7 8 9 10** | | |
| Any major change in health within the past year? ............. | ☐ | ☐ |
| If Yes, please explain: ________________________________________ | | |
| Previous Dentist __________________________ Last dental visit____________ | | |
| Last Dental x-rays_________________ | | |
| Are you currently using drugs?............................................ | ☐ | ☐ |
| If yes , explain_____________________________________________ | | |
| **<u>ALLERGIES</u>** to food/ medications/ seasonal ......................... | ☐ | ☐ |
| If Yes, please note: _________________________________________ | | |
| Are you being treated for any health problems? .................. | ☐ | ☐ |
| If yes please list____________________________________________ | | |
| Current Physicians Name______________________________________ | | |
| Physician Number (____) ________________ | | |
| Are you pregnant?.............................................................. | ☐ | ☐ |
| Due Date___________________ | | |
| Any operations/ Serious illnesses?...................................... | ☐ | ☐ |
| If Yes, explain: ________________________________________________ | | |
| Would you like to keep your natural teeth? .......................... | ☐ | ☐ |
| Not sure ___ | | |
| Any artificial joints, valves, implants or prosthesis ................. | ☐ | ☐ |
| If yes. ____________________________________________________ | | |

**Patient/ Family History**

| | Yes | No | Fam |
|---|---|---|---|
| Congenital heart lesion | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Heart trouble/ heart attack | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| heart valves/ mumur | ☐ | ☐ | ☐ |
| Stomach ulcers | ☐ | ☐ | ☐ |
| AID/ HIV | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ |
| Asthma or hay fever | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Psychiatric Problems | ☐ | ☐ | ☐ |
| Cancer or leukemia | ☐ | ☐ | ☐ |
| Hives or skin rash | ☐ | ☐ | ☐ |
| stoke | ☐ | ☐ | ☐ |
| Sexual transmitted diseases | ☐ | ☐ | ☐ |
| kidney Problems | ☐ | ☐ | ☐ |
| Alcohol use | ☐ | ☐ | ☐ |
| If Yes how many cups daily | 1-3 | 3-5 | >5 |
| | ☐ | ☐ | ☐ |
| Smoker | ☐ | ☐ | |
| Packs per day | <1 | 2-3 | |
| | ☐ | ☐ | ☐ |
| Have you ever used cocaine/heroin | ☐ | ☐ | ☐ |
| Any trouble w/ previous dental treatment | ☐ | ☐ | ☐ |

I certify that I have read and understand the above. I acknowledge that any and all questions concerning my dental needs have been answered to my satisfaction. I will not hold my dentist, her staff, or the Family Health Centers responsible for any errors or omissions that I may have made in the completion of this for. I certify that the information submitted is true and correct to the best of my knowledge.

_____________________________________      _______________________

Patient Signature      Date