

**Medical Dental History Form**

Patient Name: \_\_\_\_\_  
 Patient ID#: \_\_\_\_\_

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

Allergic to:

Latex:  Yes  No  
 Medications: \_\_\_\_\_  
 Other: \_\_\_\_\_

Physician:

Premed Required? :  Yes  No  
 Reason : \_\_\_\_\_  
 Type: \_\_\_\_\_  
 Dosage: \_\_\_\_\_

**Current Medications: prescription, over the counter, and herbal**

Medication	Dosage	Frequency

Attach list if more medications are taken

**Past and Current Medical Conditions: Mark all that apply**

	Yes		Yes
Under physician's care Details:		Diabetes Type: Controlled: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospitalization/operation in last 5 years Details:		Tobacco use: Type: Amount: If quit, what year:	
Head/neck/mouth injuries		Asthma	
Women: Pregnant		Leukemia	
Women: Nursing		Lung Disease	
Women: Oral Contraceptives		Emphysema	
Heart Trouble		Shortness of breath	
Rheumatic fever		Sleep apnea	
Mitral Value prolapsed		Sinus trouble	
Heart surgery		Cancer	
Artificial heart valves		Radiation treatment to head/neck	
Pacemaker		Chemotherapy	
Indwelling defibrillator		Kidney disease	
Artificial joints		Dialysis	
History of Organ Transplant		Eating Disorder	
High Blood Pressure BP:		Stomach trouble Reflux or Ulcer	
Stroke		Immunological disease	
Bleeding problem		Sjogrens Disease	
Hemophilia		Fibromyalgia	
Anemia		Other Autoimmune diseases: Lupus, Pemphigus	
Headaches		Depression: Diagnosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Arthritis or joint disorder		Other psychiatric disorders	
Neurologic disease		Convulsions/Epilepsy/seizures	
Fainting/dizziness		Cerebral Palsy	
AIDS/HIV positive		Alcohol or chemical dependency	
Thyroid disease		Glaucoma	
Mouth odors/bad taste		Dry mouth/excessive thirst	
Sensitive teeth? Hot, cold, pressure or sweets		Cold sores/blisters/oral lesions	
Are you aware of any lumps or swellings?		Frequency of flossing:	
Sore bleeding gums		Do you use fluoridated toothpaste	

