# Medical History

**Patient's Name**_____ **Birth Date**_____
Family Doctor_____ Doctor's Phone Number_____
Date of Last Physical Exam_____ Height_____ Weight_____

Is the patient under medical treatment now? ___yes ___no For what? _____
Has the patient ever had surgery? ___yes ___no For What? _____Date:_____
Are the patient's immunizations up to date? ____yes ____no
Has the doctor ever recommended antibiotics before dental treatment? ___yes ___no
Does the patient have a developmental disability? ___yes ___no What? _____
Does the patient smoke or use smokeless tobacco? ___yes ___no
Does the patient take any medications? ___yes ___no If yes, please list the medications:
_____

Is the patient allergic to any medications, foods, latex or other things? ____yes ____no
If yes, please list the allergies:
_____

Has the patient ever had any of the following?

| | | | |
|---|---|---|---|
| Joint Replacement | ___yes ___no | Epilepsy | ___yes ___no |
| Heart Murmur | ___yes ___no | Tuberculosis | ___yes ___no |
| Congenital Heart Problems | ___yes ___no | Diabetes | ___yes ___no |
| Artificial Heart Valves | ___yes ___no | Kidney Problems | ___yes ___no |
| High Blood Pressure | ___yes ___no | Anemia | ___yes ___no |
| Stroke | ___yes ___no | Bleeding Problems | ___yes ___no |
| History of Substance Abuse | ___yes ___no | HIV/AIDS | ___yes ___no |
| Sexually Transmitted Diseases | ___yes ___no | Autism | ___yes ___no |
| Hepatitis or Liver Disease | ___yes ___no | ADHD or ADD | ___yes ___no |
| Cancer or Radiation Treatment | ___yes ___no | Hearing Impaired | ___yes ___no |
| Asthma Problems | ___yes ___no | Psychiatric Care | ___yes ___no |
| Does the patient use an inhaler? | ___yes ___no | Female: Are you pregnant? | ___yes ___no |

Does the patient have any condition not listed? ____yes ____no If yes, please list:_____
_____
Is this the patient's first dental visit? ___yes ___no
Name of previous dentist_____ Date of last dental visit_____
Does the patient have a toothache, sore or swelling in the mouth? ___yes ___no

Is the patient in pain? ___yes ___no
If yes, please circle on Pain Rating Scale:
Location: _____ How Long?_____
What helps the pain? _____
What makes the pain worse? _____


I agree this information is accurate to the best of my knowledge.

**Signature of Parent/Guardian/Agency Staff**_____ **Date**_____
Revised: 10/15