

# MEDICAL AND DENTAL HISTORY FORM

PATIENT NAME \_\_\_\_\_  
LAST FIRST MI DATE

Reason for today's dental visit \_\_\_\_\_

## DENTAL HISTORY

Date of last dental visit: \_\_\_/\_\_\_/\_\_\_ Reason: \_\_\_\_\_

Have you ever had an experience in a dental office that you would like to tell us about? YES NO If yes, please explain \_\_\_\_\_

Are you apprehensive about dental treatment?	YES NO	Do you have discolored teeth that bother you?	YES NO
Do your gums bleed, feel tender or irritated?	YES NO	Are you unhappy with the appearance of your teeth?	YES NO
Are your teeth sensitive to hot, cold, sweets, pressure?	YES NO	Do you accept silver (amalgam) fillings?	YES NO

## MEDICAL HISTORY

Are you now seeing a physician? YES NO If yes, what is the condition being seen? \_\_\_\_\_

Date of last physical exam \_\_\_/\_\_\_/\_\_\_

Have you had any serious illness, operation, or hospitalization within the past five years? YES NO If yes, please explain \_\_\_\_\_

Please provide name, address, and telephone number of your physician:

Name Address Phone #

Please list all medications with dosages you are currently taking:

Please mark an "X" next to any item(s) you currently have or have had in the past:

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Hepatitis (Type A,B,C)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> HIV
<input type="checkbox"/> Diabetes (Type I or II)	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Cancer/ Leukemia	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Anemia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cortisone Medicine	_____
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Bronchiitis	<input type="checkbox"/> Sickle Cell Disease	_____
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Glaucoma	Do you smoke? YES NO

FEMALE: Are you pregnant or nursing? YES NO If yes, how long? \_\_\_\_\_  
Are you taking birth control pills? YES NO (NOTE: The use of antibiotics will dilute the effects of birth control pills).

Please mark an "X" next to the following items that you are allergic to:

<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Other Antibiotics	<input type="checkbox"/> Barbiturates, sedatives, or sleeping pills
<input type="checkbox"/> Aspirin	(Specify _____)	<input type="checkbox"/> Latex
<input type="checkbox"/> Iodine	<input type="checkbox"/> Codeine or other Narcotics	<input type="checkbox"/> Other _____
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa Drugs	

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to treatment by CHLOE DENTAL.

Signature of Patient/Parent/Legal Guardian Date Signature of Dentist Date

### FOR FUTURE USE

I hereby certify that all changes to my medical and dental history are noted above.

DATE	SIGNATURE OF PATIENT/ PARENT/ LEGAL GUARDIAN	DENTIST
_____	_____	_____
_____	_____	_____
_____	_____	_____