THE DENTAL GROUP MEDICAL HISTORY FORM

PATIENT NAME: _____

GENERAL INFORMATION

Are you under a physician's care? ☐ No ☐ Yes If yes, state reason: _____

Have you ever had a serious head or neck injury? ☐ No ☐ Yes If yes, please describe: _____

_____

Have you ever been hospitalized or had major surgery? ☐ No ☐ Yes If yes, please describe _____

_____

DENTAL HISTORY

What is approximate date of your last dental visit? _____ When did you last have dental x-rays?_____

MEDICATIONS Are you taking any medications, pills, drugs? ☐ No ☐ Yes If yes, please indicate below:

Medication _____dosage_____ Medication _____dosage _____

Medication _____dosage_____ Medication _____dosage _____

If yes, please indicate which ones: _____

Do you use controlled substances? ☐ No ☐ Yes Do you currently smoke or have you ever smoked? ☐ No ☐ Yes

ALLERGIES

BP _____/_____ Pulse _____

Height: _____ Weight: _____

Are you allergic to any of the following?

	No	Yes		No	Yes		No	Yes	List below any additional allergies:
Aspirin			Epinephrine			Metal			
Acrylic			Latex			Penicillin			
Codeine			Local Anesthetic			Sulfa Drugs			

Please indicate (☒) below whether you currently have, or have had in the past, any of the following conditions:

	No	Yes		No	Yes		No	Yes		No	Yes
AIDS/HIV			Chest pain/angina			Herpes			Psychiatric care		
Anaphylaxis			Cold sores/fever blisters			High blood pressure			Radiation therapy		
Anemia			Congenital heart disorder			High cholesterol			Renal dialysis		
Arthritis/Gout			Cortisone medicine			Hypoglycemia			Rheumatic fever		
Artificial Heart Valve			Diabetes			Irregular heartbeat			Sinus trouble		
Artificial Joint (hip/knee)			Drug Addiction			Kidney problems			Stomach disease		
Asthma			Epilepsy/seizure/convulsions			Leukemia			Stroke		
Blood Disease			Fainting spells/dizziness			Liver disease			Swelling of limbs		
Blood Transfusion			Heart attack/failure			Lung problems			Thyroid disease		
Breathing Problems			Heart pacemaker			Mitral valve prolapse			Tuberculosis		
Cancer			Heart trouble/disease			Osteoporosis			Tumors or growths		
Chemotherapy			Hepatitis			Pain in joints			Ulcers		

Have you ever had any serious illness not listed? ☐ No ☐ Yes If yes, please explain: _____

_____

For women – are you. . . .

Pregnant? ☐ No ☐ Yes Trying to get pregnant? ☐ No ☐ Yes Taking oral contraceptives? ☐ No ☐ Yes

Patient/Guardian Signature: _____ Date: _____

Doctor Comments: _____

_____

Doctor Signature: _____ Date: _____