FAMILY HEALTH CARE
MEDICAL AND DENTAL HISTORY

Name:_____ DOB:_____ Gender: Male Female

Address:_____
Street City State Zip

Phone:_____ Work Phone:_____

MEDICAL HISTORY

Name of Physician:_____ Phone:_____

Physician's Address:_____

When was your last physical?_____ Are your immunizations up to date? Yes No

Are you now under the care of a physician? Yes No If yes, for what reason?_____

Are you presently taking any medications/drugs/pills? Yes No Please list:_____

_____

Which pharmacy do you prefer to use:_____ Phone:_____

Are you allergic (or have an adverse reaction) to any medication or materials?

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Aspirin ☐ None

☐ Other ☐ Sulfa ☐ Other Antibiotic Please describe:_____

Are you sensitive or allergic to latex (I.e. experienced itching, rash or wheezing after using latex gloves or handling a balloon)? Yes No

Have you had any unusual or unexplained reactions during a dental procedure, including the anesthetic? Yes No

If yes, please explain:_____

Are you taking or have you taken any medications to treat osteoporosis, such as bisphosphonate? Yes No

If yes, please explain:_____

Do you have, or have you had any of the following: Please circle Yes or No

Abnormal Blood Pressure	Yes	No	Disruptive Behavior	Yes	No	Learning Disability	Yes	No
ADHD	Yes	No	Recreational Drugs	Yes	No	Liver Disease	Yes	No
Alcohol Addiction	Yes	No	Emphysema/COPD	Yes	No	Lung Disease	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Mental Health Treatment	Yes	No
Anorexia	Yes	No	Fainting Spells	Yes	No	Neurological Disorders	Yes	No
Artificial Heart Valve	Yes	No	Fibromyalgia	Yes	No	Organ Transplant	Yes	No
Artificial Joint	Yes	No	GERD	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Hearing Impaired	Yes	No	Prolonged Bleeding	Yes	No
Autism	Yes	No	Heart Attack	Yes	No	Psychiatric Care	Yes	No
Bulimia	Yes	No	Heart Disease/Surgery	Yes	No	Radiation Therapy	Yes	No
Cancer	Yes	No	Heart Infection	Yes	No	Sickle Cell Disease	Yes	No
Chemical Dependency	Yes	No	Heart Pace Maker	Yes	No	Sinus Trouble	Yes	No
Chemotherapy	Yes	No	Hemophilia/Bleeding	Yes	No	Stroke	Yes	No
Chronic Pain	Yes	No	Hepatitis ___ A ___ B ___ C	Yes	No	Thyroid Problems	Yes	No
Congenital Heart Disease	Yes	No	HIV Positive/AIDS	Yes	No	Tuberculosis	Yes	No
Cortisone Medicine	Yes	No	Immune System Disorder	Yes	No	Tumors	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Ulcers	Yes	No

Continued on Back Side

MEDICAL HISTORY Continued

Have you had n other serious illness, hospitalization or accident? Yes No

If yes, please explain: _____

Do you currently smoke or use the following tobacco products? ____ Cigarettes ____ Cigars ____ Pipe ____ Chew ____ None

Frequency: _____

Have you used tobacco products in the past? Yes No If yes, how long ago? _____

Do you drink alcoholic beverages? Yes No If yes, how much? _____

WOMEN: Are you pregnant? Yes No Are you nursing? Yes No Do you take birth control medications? Yes No

Do you anticipate becoming pregnant? Yes No

DENTAL HISTORY

Date of last dental visit? _____

Yes No Do your gums bleed while brushing or flossing?

Yes No Are your teeth sensitive to hot or cold liquids/foods?

Yes No Are your teeth sensitive to sweet or sour liquids/foods?

Yes No Do you feel pain to any of your teeth?

Yes No Do you have any sores or lumps in or near your mouth?

Yes No Have you had any head, neck or jaw injuries?

Yes No Do you have frequent headaches?

Yes No Do you clench or grind your teeth?

Yes No Do you bite your lips or cheeks frequently?

Yes No Have you ever experienced any of the folowing:

☐ Clicking in jaw ☐ Pain (joint, ear, side of face) ☐ Difficulty in opening or closing mouth ☐ Difficulty in chewing

Yes No Have you had any orthodontic work (braces)?

Yes No Have you ever had prolonged bleeding following extractions?

Yes No Have you ever had instructions on the correct method of brushing your teeth?

Yes No Have you ever had instructions on the care of your gums?

COMMENTS: _____

_____

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