



DENTAL CHOICE

MEDICAL HISTORY

Patient Name: _____

Date: _____

Address: _____

Birthdate: _____

Sex **M** **F** Height: _____ Weight: _____

For the following questions, check yes or no, whichever applies. These answers are for our records only and will be considered confidential. Please be thorough.

Yes No

- 1. Are you in good health?
- 2. Has there been any change in your general health in the past year?
- 3. Are you now under the care of a physician? If so, what is the condition being treated?

Physician's Name: _____ City: _____

- 4. Date of last physical exam: _____
- 5. Have you had any serious illness or operation? If so, what was the illness or operation?
- _____
- 6. Have you been hospitalized or had a serious illness in the last 5 years? If so, what was the problem?
- _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Sit up to sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular disease | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Coronary insufficiency | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble OR murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Coronary occlusion | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> | Pace maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic heart valves | <input type="checkbox"/> | <input type="checkbox"/> | Ankles swell | <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic joint replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart problems | <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | AIDS or related problems | <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney trouble | <input type="checkbox"/> | <input type="checkbox"/> | Inflammatory rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Received blood | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric problems | <input type="checkbox"/> | <input type="checkbox"/> | Transplant recipient |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Radiation or chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal bleeding |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder | | | |

Clarification: _____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Local anesthetics | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Antibiotics |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | | | | | | |

Signature of Dentist

Date:

Signature of patient
(Or Guardian)

Date:

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 his staff, responsible for any errors or omissions that I may have made in the completion of this form.

- | | | | | | |
|------------------------------|--|------------------------------|--|-----------------------------|---------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Frequent toothaches | <input type="checkbox"/> Yes | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> No | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> No | <input type="checkbox"/> Canker sores | <input type="checkbox"/> Yes | <input type="checkbox"/> Gum surgery | <input type="checkbox"/> No | <input type="checkbox"/> Oral surgery |
| <input type="checkbox"/> Yes | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Yes | <input type="checkbox"/> Dentures | <input type="checkbox"/> No | <input type="checkbox"/> TMI problems |
| <input type="checkbox"/> No | <input type="checkbox"/> Other | | | | |

HAVE YOU EVER HAD?

16. Do you have removable dental appliances?

15. Have you had any serious trouble associated with dental treatment? If so, what?

14. What is your chief dental complaint?

SPECIAL ORAL HISTORY

13. Sensitivity or allergy to costume jewelry?

12. Are you nursing?

11. Are you pregnant? Due Date: _____

WOMEN

10. Do you have any disease, condition or problem not listed above that our office should know about?

- | | | | | | |
|------------------------------|--|------------------------------|--|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Yes | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> No | <input type="checkbox"/> Blood thinners |
| <input type="checkbox"/> No | <input type="checkbox"/> Blood pressure medicine | <input type="checkbox"/> Yes | <input type="checkbox"/> Steroids | <input type="checkbox"/> No | <input type="checkbox"/> Tranquillizers |
| <input type="checkbox"/> Yes | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Yes | <input type="checkbox"/> Aspirin | <input type="checkbox"/> No | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> No | <input type="checkbox"/> Orinase | <input type="checkbox"/> Yes | <input type="checkbox"/> Digitalis or heart med. | <input type="checkbox"/> No | <input type="checkbox"/> Nitroglycerin |
| <input type="checkbox"/> Yes | <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Yes | <input type="checkbox"/> Hormone therapy | <input type="checkbox"/> No | <input type="checkbox"/> Inhalers |
| <input type="checkbox"/> No | <input type="checkbox"/> Other: | | | | |

ARE YOU TAKING THE FOLLOWING MEDICATIONS?