# DENTAL ASSOCIATES - MEDICAL HISTORY FORM

****Please complete the front & back of this form****

_____ Birthdate: ____/____/____

**Last Name** **First Name** **Middle**

General Physician Name: _____ Phone #_____

Physician Address/City/Zip: _____

Date of last Physical Exam: _____

Emergency Contact Person: _____ Relationship to pt: _____

Emg.Contact Phone #'s: Home _____ Cell _____ Work _____

Pharmacy:_____ Phone # _____

1. For the following questions, *circle* ***yes or no,*** whichever applies.
   Your answers are for our records only & are considered confidential.

| | | | | | |
|---|---|---|---|---|---|
| HIV/AIDS | Y N | Congenital Heart Disease/or Other Heart Disease | Y N | Osteoporosis | Y N |
| Anticoagulation Therapy | Y N | | | Pacemaker | Y N |
| Artifical (Prosthetic) Heart Valve | Y N | Diabetes | Y N | Previous Infective Endocarditis | Y N |
| | | Heart Murmur | Y N | Prosthesis/Artifical Joint | Y N |
| Arthritis | Y N | Hepatitis | Y N | Seizures | Y N |
| Asthma | Y N | High Blood Pressure | Y N | Stroke | Y N |
| Bleeding Disorders | Y N | Hypoglycemia | Y N | Tuberculosis | Y N |
| Cancer | Y N | Kidney Disease/Dialysis | Y N | Thyroid Disease | Y N |
| Chemotherapy | Y N | Intravenous Devices/Shunts/ Filters | Y N | Sexually Transmitted Disease | Y N |
| | | | | Other: _____ | |

2. Have you experienced any difficulty with previous Dental treatment? ☐ Yes / ☐ No ~ If yes, please explain: _____

_____

_____

_____

3. Have you had any surgery? ☐ Yes / ☐ No *If yes, please list your surgery & date of surgery:

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

4. Do you require Antibiotic Pre-medication prior to any dental work? ☐ Yes / ☐ No
   If yes, please state reason & medication:_____

_____

**Please turn over & complete 2nd page** ➔

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## Patient Name:

5. List any medication you are currently taking (include over-the-counter medicine/aspirin):

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

6. List any allergies (Especially: Penicillin, Aspirin, Codeine, or Latex): _____
_____
_____

7. Do you smoke? ☐ Yes / ☐ No If yes, how much? _____

8. Have you ever been told you snore? Y or N

9. Have you ever had a sleep study? Y or N If yes, when? _____

10. Have you ever been diagnoses with Sleep Apnea? Y or N If yes, do you wear a CPAP or oral appliance? Y or N _____

- If you could change one thing about your smile, what would it be?_____
  _____
  _____
- Would you be interested in a simple, effective way to whiten your smile? ☐ Yes ☐ No

WOMEN ONLY PLEASE ANSWER: Y = YES *or* N = NO

Are you pregnant? _____ If yes, how long?_____ Are you nursing?_____
Are you taking birth control pills? _____
Are you experiencing post-menopausal disorders such as Osteoporosis?_____ If yes, please explain:
_____

**I FULLY UNDERSTAND THAT FOR DENTAL ASSOCIATES TO ADMINISTER PROPER DENTAL TREATMENT, I MUST KEEP DENTAL ASSOCIATES AWARE OF ANY CHANGES IN MY HEALTH AND, TO THE BEST OF MY KNOWLEDGE, ALL THE PROCEEDING ANSWERS ARE CORRECT.**

**Patient Signature** _____ **Reviewers Initials** _____ **Date** _____

**Patient Signature** _____ **Reviewers Initials** _____ **Date** _____

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