Patient Medical History Form

PATIENT INFORMATION

Patient Number: ______________ Age: _________ DOB: __________________ Sex: __________
Patient Name: ____
Home Address: ____
Home Phone: ____________________________ Cell Phone: ____________________________

Father / Husband: ________________________ Employer: _____________________Work #:___________
Mother / Wife: ___________________________ Employer: _____________________Work #:___________
E-Mail: ____

Name of Dentist: **Date of last dental examination/visit:**
Referred by:

MEDICAL HISTORY

Y N Heart Trouble
Y N Congenital Heart Defect/HeartMurmur
Y N Heart Surgery/Pacemaker
Y N Abnormal Bleeding/Hemophilia
Y N Artificial Bone/Joint/Valve
Y N Bone Disorders/Osteoporosis
Y N Taking/ever taken Bisphosphonates
Y N Numerous Broken Bones
Y N Kidney/Liver/Spleen problems/missing
Y N Convulsions/Epilepsy
Y N Rheumatic/Scarlet Fever
Y N Radiation Treatment/Chemotherapy

Y N Diabetes
Y N Cancer
Y N Arthritis
Y N Tonsilitis
Y N Asthma
Y N Contact Lens
Y N HIV+/AIDS
Y N Any Surgeries (list below)

Y N Allergic to Latex
Y N Allergic to Plastic/Acrylics
Y N Allergic to Metals/Nickel
Y N Allergic to Dental Anesthetics
Y N Allergic to Other:_________ (besides medications)
Y N Women: Are you pregnant

Drugs or medications now taking ____
Allergies to any drugs or medications____
Any other medical problems, conditions or surgeries_________________________________

Have you ever had:

Y N Tonsils or Adenoids been removed? If yes, when?____________________
Y N Do you snore at night?
Y N Do you grind your teeth at night?
Y N Any traumatic dental treatments?
Y N Had a previous orthodontic examination?
Y N Gums bleed when brushed?
Y N Did you ever suck your fingers, lip or other objects? If stopped, at what age ________
Y N Have you ever received a severe blow to the head or jaw?
How often do you brush your teeth? ____

List your hobbies and special interests: ____
Favorite Movie: ______________Music:_____________________TV Show:_______________
Patient's Occupation / School Level: ____
School: ________________________________ Favorite Class: ____________________
What do you like most about your career or classes in School: ___________________________
When you have free time, what do you like to do? ____________________________________

Sign____ Date__________________