HappyTeeth
FAMILY DENTISTRY

MEDICAL HISTORY

To receive treatment in our office, please answer all of the following questions. All information will be held in the strictest confidence and will not be disclosed to anyone without your written permission.

Name _____ Birthdate _____
Physician's Name _____ Date of last visit to your doctor_____
Physician's Phone _____ Purpose of visit _____

Do you have, or have you had, any of the following?

	YES	NO
Heart problems?	☐	☐
Congestive heart failure	☐	☐
Congenital heart malformation	☐	☐
Heart valve problems/murmur	☐	☐
Artificial heart valve	☐	☐
Chest pain/angina	☐	☐
Heart attack/myocardial infarct	☐	☐
Cardiac arrhythmia	☐	☐
Pacemaker	☐	☐
Vascular problems?	☐	☐
High/low blood pressure	☐	☐
Fainting/dizziness	☐	☐
Stroke/TIA	☐	☐
Bleeding disorders?	☐	☐
Easy bruising	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusions	☐	☐
Breathing problems?	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐
Bronchitis	☐	☐
Persistent cough	☐	☐
Obstructive sleep apnea	☐	☐
Hepatitis, jaundice, cirrhosis?	☐	☐
Intestinal disease?	☐	☐
Gastric reflux	☐	☐
Ulcers	☐	☐
Colitis, Crohn's, IBS	☐	☐
Weight gain/loss	☐	☐
Kidney problems or renal dialysis?	☐	☐

	YES	NO
Diabetes?	☐	☐
Frequent thirst/urination	☐	☐
Family history of diabetes	☐	☐
Bone or joint problems?	☐	☐
Osteoporosis	☐	☐
Joint replacement surgery	☐	☐
Back or neck pain	☐	☐
Immunologic conditions?	☐	☐
Lupus	☐	☐
Other autoimmune diseases	☐	☐
Immunosuppressive therapy	☐	☐
Prednisone use	☐	☐
Cancer?	☐	☐
If yes, what type? _____		
Radiation	☐	☐
Chemotherapy	☐	☐
Surgery	☐	☐
Psychiatric issues?	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Autism	☐	☐
Behavior issues	☐	☐
Alzheimer's or dementia	☐	☐
Neurologic problems?	☐	☐
Seizures, epilepsy	☐	☐
Parkinson's	☐	☐
Cerebral palsy	☐	☐
Infectious diseases?	☐	☐
HIV+, AIDS	☐	☐
Other sexually transmitted disease	☐	☐

	YES	NO
Do you smoke or chew tobacco? ……..	☐	☐
If yes, how much? _____		
Do you drink alcoholic beverages? ……	☐	☐
If yes, indicate frequency:_____		
Any history of marijuana or illicit drug use? …….	☐	☐

FEMALES:	YES	NO
Are you pregnant? ……..	☐	☐
If yes, when are you due? _____		
Are you taking birth control pills? ……..	☐	☐
Are you breastfeeding? ……..	☐	☐

Please list all medications (including dosages) that you are taking: _____

_____

_____

Are you allergic or have you had an adverse reaction to any drug or medication? ☐ YES ☐ NO

If yes, list medication and describe reaction: _____

_____

Describe any other medical conditions that you are aware of:

_____

_____

DENTAL HISTORY

When was your last dental visit? _____

Reason for your last dental visit? _____

Have you ever taken antibiotics for dental treatment? _____

Please indicate if you have/had any of the following:

	YES	NO
Bad breath……..	☐	☐
Bleeding or tender gums……..	☐	☐
Blisters/sores on lip/mouth ……..	☐	☐
Cheek or lip biting……..	☐	☐
Clenching/grinding teeth……..	☐	☐
Clicking or popping jaw……..	☐	☐
Dry mouth……..	☐	☐
Food caught between teeth ……..	☐	☐

	YES	NO
Jaw pain or soreness……..	☐	☐
Loose teeth……..	☐	☐
Orthodontics ……..	☐	☐
Pain on biting……..	☐	☐
Periodontal treatment……..	☐	☐
Sensitivity to cold……..	☐	☐
Sensitivity to heat……..	☐	☐

What are your present dental concerns or needs? _____

_____

I have read and understand the questions on the health history. I have answered them to the best of my ability.

Person completing the form:

Signature: _____

Print Name: _____

If other than patient, indicate relationship: _____

Date: _____

For Office Use Only:	
Dentist's Review and Significant Findings:	
Dentist's Signature:	Date: