HOUSE DMD
FAMILY DENTAL

Patient Name: _____ **Date:** _____

Patient Medical and Dental History

Although dental personnel primarily treat dental conditions, your mouth is part of your entire body. Health problems you may have or medications you may be taking could have an effect on the dentistry you will receive.

Dental History:

Primary reason for this dental appointment: ☐ Exam ☐ Emergency ☐ Consultation
Do you have a specific dental problem? Please explain: _____
Do you think you have active decay or gum disease? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No
Do you like your smile? ☐ Yes ☐ No
Do you want to keep your remaining teeth? ☐ Yes ☐ No
Do have clicking, popping, or discomfort in the jaw joints? ☐ Yes ☐ No
When was your last dental visit? _____ When was your last dental cleaning?_____

Medical History:

Are you under the care of a physician? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Please list: _____
Have you received treatment for osteoporosis? ☐ Yes ☐ No If yes, please explain: _____
Do you use tobacco? ☐ Yes ☐ No If yes, (circle one): Smoke Chew

Are you allergic to any of the following?

☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics

Other: (Please be specific) _____

Women:

Are you: ☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives?

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

☐ Angina	☐ Anemia	☐ Arthritis/Gout	☐ Chemotherapy
☐ Heart Attack	☐ Scarlet Fever	☐ Artificial Joint	☐ Radiation Treatments
☐ Heart Murmur	☐ Asthma	☐ Swelling of the Limbs	☐ Leukemia
☐ Mitral Valve Prolapse	☐ Easily Winded	☐ Cortisone Medication	☐ Liver Disease
☐ Congenital Heart Disorder	☐ Emphysema	☐ Ulcers	☐ Hepatitis A, B, or C
☐ Pace Maker	☐ Lung Disease	☐ Frequent Diarrhea	☐ Drug Addiction
☐ Chest Pain	☐ Tuberculosis	☐ Gastric Reflux Disease	☐ AIDS/HIV
☐ Irregular Heartbeat	☐ Hay Fever	☐ Recent Weight Loss	☐ Venereal Disease
☐ Artificial Heart Valve	☐ Sinus Trouble	☐ Eating Disorder	☐ Shingles
☐ High Blood Pressure	☐ Frequent Headaches	☐ Diabetes	☐ Psychiatric Care
☐ Low Blood Pressure	☐ Stroke	☐ Hypoglycemia	☐ Down Syndrome
☐ Excessive Bleeding	☐ Fainting Spells/Dizziness	☐ Excessive Thirst	☐ Autism
☐ Bruise Easily	☐ Epilepsy/Seizures	☐ Kidney Problems	☐ Special Needs (please specify)
☐ Rheumatic Fever	☐ Alzheimer's	☐ Renal Dialysis	
☐ Hemophilia	☐ Glaucoma	☐ Cancer	

Have you had any other serious illness not listed above? ☐ Yes ☐ No If yes, please list: _____
Emergency Contact: _____ Phone Number: (____) _____
Physician Name: _____ Phone Number: (____) _____
Preferred Pharmacy: _____ Phone Number: (____) _____

To the best of my knowledge, I have accurately answered the questions on this form. I understand providing incorrect or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform House Family Dental of any changes in medical status in a timely manner.

Signature: _____ Date: _____