Medical History 2020 (8-20)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯Yes◯No	If yes
Have you ever been hospitalized or had a major	◯Yes◯No	If yes
Has there been a change in your general health since your last visit?	◯Yes◯No	If yes
Have you ever been premedicated with antibiotics prior to medical/dental treatment?	◯Yes◯No	If yes
Are you on a special diet or nutritional plan? (To lose weight, low salt, diabetic, low cholesterol, ulce	◯Yes◯No	If yes
Do you use controlled substances?	◯Yes◯No	If yes
Have you taken Phen-Fen or Redux?	◯Yes◯No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates	◯Yes◯No	If yes
Have you had close contact with or cared for someone with a communicable disease?	◯Yes◯No	If yes
Have you traveled outside the state of Illinois in the last 14 days?	◯Yes◯No	If yes

Do you have any of the following symptoms or have had any any of these symptoms in the last 10 days?

Fever or chills	◯Yes ◯No	Shrtness of breath or difficulty breathing	◯Yes ◯No	Cough	◯Yes ◯No
Loss of smell	◯Yes ◯No	Loss of taste	◯Yes ◯No	Congestion	◯Yes ◯No
Headache	◯Yes ◯No	Nausea	◯Yes ◯No	Muscle or body aches	◯Yes ◯No
Fatique	◯Yes ◯No	Sore throat	◯Yes ◯No	Runny nose	◯Yes ◯No
Diarrhea	◯Yes ◯No	Vomiting	◯Yes ◯No		

Comments:

Women: Are you...

☐Pregnant/Trying to get pregnant? ☐Nursing? ☐Have you had any complications?

Do you/have you ever used tobacco?	◯Yes◯No	
Type of tobacco used		omment
How many per day?		omment
How long is/was the habit?		omment
Interested in quitting?	◯Yes◯No	If yes

Do you consume alcoholic beverages?	◯Yes◯No	
What kind?		omment
How many per day?		
How long is the habit?		

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

Heart Trouble/Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No	Sickle Cell Anemia ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Heart Attack/Trouble ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No
Heart Murmur ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No
Heart Pacemaker ◯ Yes ◯ No	Emphysema/COPD ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Heart Surgery ◯ Yes ◯ No	Tuberculosis (TB) ◯ Yes ◯ No	Bruises Easily ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Herpes/Cold Sores/Fever Blisters ◯ Yes ◯ No
Irregular Heart beat ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Sexually Transmitted Disease ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No	Frequent Cough/Blood Yielding Cough ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	HPV ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Mononucleosis ◯ Yes ◯ No
Low Blood Pressure ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis B ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
High Cholesterol ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Hepatitis C ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Congenital Heart Defect ◯ Yes ◯ No	Thyroid/Parathyroid Disease ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	HIV/AIDS ◯ Yes ◯ No
Rheumatic Fever ◯ Yes ◯ No	Epilepsy/Seizure ◯ Yes ◯ No	Nervousness/Anxiety ◯ Yes ◯ No	Contagious Disease in past 3 months ◯ Yes ◯ No
Scarlet Fever ◯ Yes ◯ No	Stomach/Intestinal Problems ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Angina/Chest Pain ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No
Swelling of Limbs/Hands/Feet ◯ Yes ◯ No	Autism ◯ Yes ◯ No	Eating Disorder ◯ Yes ◯ No	Cancer (Malignant) ◯ Yes ◯ No
Stroke ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Unexplained Recent Weight Loss ◯ Yes ◯ No	Tumors or Growths (Benign) ◯ Yes ◯ No
Frequent Headaches ◯ Yes ◯ No	Loss of Sight/Hearing ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No	Chemotherapy/Radiation ◯ Yes ◯ No
Fainting Spells/Diziness ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Allergies

Are you allergic to any of the following?

Anesthetic ◯ Yes ◯ No	Sulfa drugs ◯ Yes ◯ No	Aspirin, Ibuprofen, acetaminophen ◯ Yes ◯ No
Environmental (dust, pollen, etc.) ◯ Yes ◯ No	Codeine ◯ Yes ◯ No	Foods, food preservatives/additives, foo ◯ Yes ◯ No
Iodine ◯ Yes ◯ No	Latex ◯ Yes ◯ No	Penicillin, amoxicillin, etc ◯ Yes ◯ No

Other ◯ Yes ◯ No If yes

Medications

Are you taking any of the following?

Anticonvulsants (antiepilectics) ◯ Yes ◯ No	Cortisone(steroids), prednisone ◯ Yes ◯ No	Contraceptives ◯ Yes ◯ No	Antidepressants, Tranquilizers ◯ Yes ◯ Nc
Digitalis, heart medication ◯ Yes ◯ No	Cancer medications ◯ Yes ◯ No	Antihistamines, Decongestants ◯ Yes ◯ No	Diuretics ◯ Yes ◯ Nc
Thyroid medications ◯ Yes ◯ No	Antibiotics ◯ Yes ◯ No	High blood pressure medications ◯ Yes ◯ No	Ulcer medications, acid-reflux medication ◯ Yes ◯ Nc
Anticoagulants (blood thinners) ◯ Yes ◯ No	Insulin, Diabetes medication ◯ Yes ◯ No	Weight control medication ◯ Yes ◯ No	Aspirin, ibuprophen, acetaminophen ◯ Yes ◯ Nc
Minerals, vitamins, herb, food supplement ◯ Yes ◯ No	Other ◯ Yes ◯ No	Bronchodialators ◯ Yes ◯ No	Nitroglycerine ◯ Yes ◯ Nc

Vitals and ASA

BP:

Pulse:

Respiration:

Temperature:

ASA:

Signatures

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Signature of Student Dental Hygienist:

X Date:_____