Medical History

Patient Name: Birth Date:Click here to enter a date.Date Created:Click here to enter a date.

Are you under a physician's care now? ☐Yes ☐No If yes,
Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes,
Have you ever had a serious head or neck injury? ☐Yes ☐No If yes,
Are you taking any medications, pills, or drugs? ☐Yes ☐No If yes,
Are you on a special diet? ☐Yes ☐No If yes,
Do you use tobacco, cigarettes, e-cigs, chewing tobacco? ☐Yes ☐No If yes,
Do you use controlled substances? ☐ ☐ If yes,
Do you wear

Women: Are you…..
☐Pregnant/Trying to get pregnant ☐Nursing ☐Taking oral contraceptives

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Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic
☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthetics
☐Other? If yes,

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

AIDS/HIV Positive ☐Yes ☐No	Drug Addiction ☐Yes ☐No	Herpes ☐Yes ☐No	Shingles ☐Yes ☐No
Anaphylaxis ☐Yes ☐No	Easily Winded ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Sickle Cell Disease ☐Yes ☐No
Anemia ☐Yes ☐No	Emphysema ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Sinus Trouble ☐Yes ☐No
Angina ☐Yes ☐No	Epilepsy or Seizures ☐Yes ☐No	Hypoglycemia ☐Yes ☐No	Spina Bifida ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No	Excessive Bleeding ☐Yes ☐No	Irregular Heartbeat ☐Yes ☐No	Stomach/Intestinal ☐Yes ☐No
Artificial Joint ☐Yes ☐No	Excessive Thirst ☐Yes ☐No	Kidney Problems ☐Yes ☐No	Swelling of Limbs ☐Yes ☐No
Asthma ☐Yes ☐No	Fainting Spells/Dizziness ☐Yes ☐No	Leukemia ☐Yes ☐No	Thyroid Disease ☐Yes ☐No
Blood Disease ☐Yes ☐No		Liver Disease ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Blood Transfusion ☐Yes ☐No	Frequent Cough ☐Yes ☐No	Low Blood Pressure ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Breathing Problems ☐Yes ☐No	Frequent Diarrhea ☐Yes ☐No	Lung Disease ☐Yes ☐No	Tumors or Growths ☐Yes ☐No
Bruise Easily ☐Yes ☐No	Frequent Headaches ☐Yes ☐No	Mitral Valve Prolapse ☐Yes ☐No	Ulcers ☐Yes ☐No
Chest Pains ☐Yes ☐No	Hay Fever ☐Yes ☐No	Pain in Jaw Joints ☐Yes ☐No	STD ☐Yes ☐No
Cold Sore/Fever Blister ☐Yes ☐No	Heart attack/Failure ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	
	Heart Murmur ☐Yes ☐No	Recent Weight Loss ☐Yes ☐No	
Congenital Heart Disorder ☐Yes ☐No	Heart Trouble ☐Yes ☐No	Renal Dialysis ☐Yes ☐No	
	Hepatitis A ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No	
Diabetes ☐Yes ☐No	Hepatitis B or C ☐Yes ☐No	Scarlet Fever ☐Yes ☐No	

Have you ever had any serious illness not listed? ☐Yes ☐No If yes,

Comments:

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 Parent or Guardian: _____ Date: Click here to enter a date.

Family History

	Siblings	Mother	Father	Mother's Parents	Father's Parents
Alcoholism	☐	☐	☐	☐	☐
Asthma, Lung Disease	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes (specify type)	☐	☐	☐	☐	☐
Epilepsy, seizure disorder	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Mental illness, depression, anxiety, ADHD, etc.	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Other (specify)					

Please list any other information that you feel is pertinent to your child's medical care: