Community Dental Clinics **Medical History**

Patient Name ____ **Date of Birth** _____ /_____ /_____
Last First Middle

Today's Date _____________________

Please complete by circling your response:

Do you have any of the following diseases or problems?

1. Yes No Active Tuberculosis
2. Yes No A Persistent Cough or cough that that produces blood
3. Yes No Been exposed to anyone with Tuberculosis

If you answered yes to any of these questions, please stop and talk to your dentist or the receptionist.

4. Yes No Are you under the care of a physician? ___________________
5. Yes No Have you had a serious illness, operation or hospitalization in the last 5 years?
6. Yes No Have you had an organ transplant? Which one___________________ When_________
7. Yes No Have you had a joint replacement? Which one___________________ When_________
8. Yes No Do you take any blood thinners, anticoagulants?
9. Yes No Have you ever had cancer or tumors? Where ____________________ When_________
10. Yes No Have you been treated with radiation or chemotherapy? When_____________________
11. Yes No Have you taken steroids (e.g. cortisone) in the last 2 years? When__________________
12. Yes No Have you taken any medications for bone loss (bisphosphonates)? For how long_________
13. Yes No Do you use tobacco? Smoke Snuff Chew Other
14. Yes No Do you drink alcoholic beverages? How many per day __________ per week _________
15. Yes No Do you use recreational drugs? What kind____________________ how much_________

Women Only

16. Yes No Are you pregnant or nursing?
17. Yes No Do you take birth control pills, fertility drugs, or hormone replacement?

Children Only

18. Yes No Are your child's immunizations up to date?
19. Yes No Does your child have attention Deficit Hyperactivity Disorder?
20. Yes No Does your child have a learning disability?

21. Yes No Do you have allergies to any medications (including metals)? (if yes please list)

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22. Yes No Are you taking any medications (including any supplements)? Please list below:

Medication	Dose/ Frequency	Reason	

23. Yes No Do you now have or have you ever had any of the following infectious diseases?

☐ HIV/AIDS ☐ Hepatitis Type _________ ☐ STD______________________

☐ Cold Sores ☐ Other____

24. Yes No Do you have any cardiovascular (heart and circulation) disorders? Which one(s)?

☐ Artificial Valve(s) ☐ High Blood Pressure ☐ Low Blood Pressure
☐ Heart Murmur ☐ Mitral Valve Prolapse ☐ Angina
☐ Pacemaker ☐ Heart Attack ☐ Heart Disease
☐ Rheumatic Fever ☐ Congenital defect ☐ Congestive Heart Failure
☐ Other____

25. Yes No Do you have any neurological (brain or nerves) disorders? Which one(s)?

☐ Stroke/TIA ☐ Seizures/epilepsy ☐ Multiple Sclerosis
☐ Headaches ☐ ADD/ADHD ☐ Psychiatric Disorders
☐ Parkinson's ☐ Dementia/Alzheimer's ☐ Other ____________________

26. Yes No Do you have any Respiratory (Lung/Breathing) disorders? Which one(s)?

☐ Asthma ☐ Emphysema/COPD ☐ Tuberculosis ☐ Sinusitis
☐ Bronchitis ☐ Sleep Apnea/Snoring ☐ Other____________________

27. Yes No Do you have any Endocrine (Gland) disorders? Which one(s)?

☐ Diabetes: Type____ ☐ Adrenal Gland
☐ Hypothyroidism ☐ Hyperthyroidism ☐ Other____________________

28. Yes No Do you have any Hematologic (Blood) disorders? Which one(s)?

☐ Anemia ☐ Sickle Cell ☐ Leukemia ☐ Lymphoma
☐ Multiple Myeloma ☐ Other____________________

29. Yes No Do you have any Kidney/ Urogenital/ Digestive disorders? Which one(s)?

☐ Kidney Failure ☐ Dialysis ☐ Acid Reflux/GERDS ☐ Frequent Urination
☐ Hepatitis_____ ☐ Cirrhosis ☐ Prostate ☐ Jaundice
☐ Heartburn ☐ Ulcers ☐ Crohn's Disease ☐ Irritable Bowel
☐ Other ____

30. Yes No Do you have Musculoskeletal/ Connective Tissue disorders? Which one(s)?

☐ Arthritis ☐ Osteoporosis ☐ TMJ ☐Other____________________

31. Yes No Do you have (or ever had) an eating disorder? ____________________
32. Yes No Do you have any Ear, Eye, Nose, or Throat problems? ____________________
33. Yes No Do you have any Dermatologic (Skin) disorders?____________________

To the best of my knowledge, the preceding information is complete and accurate.

Signature______________________________Date:____________________

Relationship (if other than patient)______________________________

Dentist Signature ______________________________Date____________________