Staff Initials: ___________

PATIENT MEDICAL HISTORY FORM

1690 Wright Avenue Rocky River, OH 44116

Patient Name: ______________________ **Date of Birth:** ___________ **Date:** ___________

Patient Address: ______________________________________

Patient Email: ______________________

Medical

	Yes	No
Has there been a major change to your health within the past year?	☐	☐
If yes, please explain: ______________		
Are you under the care of a physician or are you receiving ongoing medical care?	☐	☐
Name of your physician: ______________		
Physician's Phone Number: ______________		
Date of your last medical visit: ______________		
Are you pregnant?	☐	☐
If Yes, due date: ______________		
Do you have any artificial joints, heart valves, implants, or prosthesis?	☐	☐
Have you ever been told you need to be pre-medicated prior to dental treatment?	☐	☐

Dentist Comments: ______________

____

Dental

	Yes	No
Are you having any dental discomfort at this time?	☐	☐
If yes, please explain: ______________		
Have you ever had serious trouble with previous dental work?	☐	☐
If yes, please explain: ______________		
Does dental work make you nervous?	☐	☐
Have you ever had any abnormal bleeding associated with previous extractions or surgery?	☐	☐
If yes, please explain: ______________		

Date of your last dental visit: ______________

How often do you brush your teeth? ______________

How often do you floss your teeth? ______________

Other:

Please check "Yes" or "No":

	Yes	No
Do you use tobacco?	☐	☐

If so, how much ______________

What Type: ______________

____

Medications

	Yes	No
Are you taking any prescription or over-the-counter medications?	☐	☐

Please list all medications you are taking (or attach printed list):

	Medication:	Dosage:	How Often Taken:	Reason for Medication:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Allergies

	Yes	No
Are you allergic to anything?	☐	☐

Please list all allergies including reaction:

	Allergy to:	Reaction:
1.		
2.		
3.		
4.		

Patient Name: ______________________ Date of Birth: ____________ Date: ____________

PATIENT MEDICAL HISTORY FORM

Medical Information:
Please check the answer that is right for you. If you do not know, you can leave the answer blank.

Heart and Circulatory Problems

	Yes	No
Heart Attack	☐	☐
If yes, when ________		
High Blood Pressure	☐	☐
Chest Pain (Angina)	☐	☐
Heart Murmurs	☐	☐
Artificial Valves	☐	☐
Pacemaker	☐	☐

	Yes	No
Diabetes - Type I	☐	☐
Diabetes - Type II	☐	☐
Thyroid Problems	☐	☐

Comments ________

Breathing/Lung Problems

	Yes	No
Sleep Apnea	☐	☐
Shortness of Breath	☐	☐
Persistent Cough	☐	☐
Positive Test/Treatment for Tuberculosis	☐	☐
Seasonal Allergies	☐	☐
Asthma	☐	☐
Emphysema	☐	☐

Comments ________

Skin Problems

	Yes	No
Rashes	☐	☐
Oral Herpes/"Cold Sores"	☐	☐
HPV	☐	☐

Stomach Problems

	Yes	No
Heartburn	☐	☐
History of Ulcers	☐	☐
Colitis	☐	☐

Comments ________

Mental Health Problems

	Yes	No
Depression	☐	☐
Anxiety	☐	☐
History of Psychiatric Medications	☐	☐

Comments ________

Muscle and Bone Problems

	Yes	No
Joint/Back Pain	☐	☐
Joint Swelling	☐	☐
Arthritis	☐	☐

Comments ________

Liver

	Yes	No
Hepatitis A, B, or C	☐	☐
Other Liver Disease	☐	☐
Jaundice	☐	☐

Comments ________

Neurologic Problems

	Yes	No
Epilepsy/Seizures	☐	☐
Chronic Headaches	☐	☐
History of Head Injury	☐	☐
History of Stroke	☐	☐
If yes, when ________		
Fainting Spells	☐	☐

Comments ________

Blood Problems

	Yes	No
Bleeding Problems	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Are you taking blood thinners?	☐	☐

If yes, recent INR level ________

Comments ________

Other

	Yes	No
Immune System Disorders	☐	☐
History of Cancer	☐	☐
Comments ________		
AIDS/HIV	☐	☐
Kidney or Bladder Problems	☐	☐
Frequent Urinary Tract Infections	☐	☐

Comments ________

	Yes	No
Do you have any other disease, condition or problem not listed?	☐	☐

If Yes, please explain ________

____

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct.

____

Signature of Patient/Guardian   Date   Hygienist Signature   Dentist Signature

Updates:

____
____
____
____
____
____
____
____

Rev Jan2013 CRD