

Dental Medical History Form

Patient Information

Patient Name: _____

Date of Birth: _____ Age: _____ Gender: Male Female Other

Phone: _____ Email: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Primary Care Physician

Physician Name: _____

Physician Phone: _____

Date of Last Physical Exam: _____

Medications

Please list **all medications**, including over-the-counter drugs and supplements.

Medication(s):

Allergies

Have you ever had an allergic reaction to any of the following?

- Penicillin / Amoxicillin
- Latex
- Aspirin
- Codeine
- Local anesthetics
- Metals
- Other: _____

Describe reaction: _____

Medical History

Please check **YES** or **NO** for each condition.

Condition	Yes	No	Condition	Yes	No
Heart disease / heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur / valve disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease / Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Seizures / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (Type I / Type II)	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety / Depression	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	GERD / Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>
COPD / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Bisphosphonate use	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (type): _____	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy / Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Nursing	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>			

If YES to any above, please explain:

Please list **any other medical conditions, diagnoses, surgeries, or hospitalizations** not already listed above.

Approximate dates / details (if applicable):

Dental History

Reason for today's visit: _____

Question	Yes	No
Do you have dental anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had complications with dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had periodontal (gum) treatment?	<input type="checkbox"/>	<input type="checkbox"/>

Date of last dental visit: _____

Social History

- Tobacco use (current/former)
- Vaping
- Alcohol use
- Recreational drug use

Consent & Acknowledgment

I certify that the information provided is complete and accurate to the best of my knowledge. I understand that providing incorrect or incomplete information may affect my dental care.

Patient Signature: _____

Date: _____