Patient Medical History Form

Date: ____/____/____

Patient's Name: _____ Date of Birth: _____

Parent/Guardian (for minors) _____ General Dentist: _____

What are your main concerns or has the dentist told you of any concerns? _____

_____

Has the patient ever been evaluated for this concern? Yes ___ No ___

Has the patient had orthodontic treatment before? Yes ___ No ___

Have there been any injuries to the face, mouth, teeth or chin? Yes ___ No ___

If yes, please explain: _____

Has the patient ever had any pain/tenderness in his/her jaw joint (TMJ)? Yes ___ No___

The patient's current dental health is: Good ___ Fair ___ Poor ___

Have you been informed of any missing or extra permanent teeth? Yes ___ No ___

Has the patient ever had any of the following medical/dental problems?

Yes ___ No ___ Clenching / Grinding
Yes ___ No ___ Lip Sucking / Biting
Yes ___ No ___ Mouth Breather
Yes ___ No ___ Nail Biting
Yes ___ No ___ Speech Problems
Yes ___ No ___ Thumb / Finger Sucking
Yes ___ No ___ Tongue Thrust

The patient's current physical health is: Good ___ Fair ___ Poor ___

Is the patient currently under the care of a physician: Yes ___ No ___
If yes, please explain:

_____

For Adolescents: Has puberty begun? Yes ___ No ___ **For Girls**: Has menstruation begun? Yes ___ No ___ Date: _____

Please list all the medications the patient is currently taking: _____

Please list all the medications / things that the patient is allergic to _____

The patient has / has had the following diseases or medical problems:

Yes ___ No ___ Abnormal Bleeding/Hemophilia
Yes ___ No ___ ADD/ADHD
Yes ___ No ___ Allergies to any medications
Yes ___ No ___ Allergies to Latex
Yes ___ No ___ Any Hospital Stays
Yes ___ No ___ Artificial Bones/Joints
Yes ___ No ___ Artificial Valves
Yes ___ No ___ Arthritis
Yes ___ No ___ Asthma
Yes ___ No ___ Autism
Yes ___ No ___ Cancer
Yes ___ No ___ Congenital Heart Defects
Yes ___ No ___ Convulsions/Epilepsy
Yes ___ No ___ Diabetes
Yes ___ No ___ Handicaps/Disabilities
Yes ___ No ___ Hearing Impairment
Yes ___ No ___ Heart Murmur
Yes ___ No ___ Heart Surgery
Yes ___ No ___ Hepatitis
Yes ___ No ___ HIV / AIDS
Yes ___ No ___ Mitral Valve Prolapse
Yes ___ No ___ Kidney/Liver Problems
Yes ___ No ___ Rheumatic /Scarlet Fever
Yes ___ No ___ Tuberculosis (TB)
Yes ___ No ___ Taking Osteoporosis Medication
(Not Including Vitamin D/Calcium)

Please list any serious medical condition(s) that the patient has ever had:

_____

I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform any necessary dental services that may be needed during the diagnosis and treatment with my informed consent.

Signature of Patient or Parent /Guardian: _____ **Date:** ____/____/____

Updated: _____ **Updated:** _____ **Updated:** _____