Patient Medical History

1st Family Dental
www.1fd.org

Patient Name: _____ Date of Birth: _____ Gender: _____ Age: _____

Preferred Pharmacy: _____ Address: _____ Zip code: _____

Although Dental personnel primarily treat the area in and around your mouth, your dental health can affect your overall health in many ways. Health problems you may have, or medications you may be taking, could have an important interrelationship with the dental treatment you may receive. Thank you for answering the following questions completely and accurately.

General Medical History

Are you under a physician's care now? ___ Yes ___ No If Yes, Please Explain: _____

Have you ever had a serious head/neck injury? ___ Yes ___ No If Yes, Please Explain: _____

Are you taking any medications/pills/drugs? ___ Yes ___ No If Yes, Please List: _____

Have you been hospitalized or had a major operation? ___ Yes ___ No If Yes, Please Explain: _____

Have you taken, or do you take, Phen-Fen or Redux? ___ Yes ___ No _____

Are you on a special diet? ___ Yes ___ No _____

Do you use tobacco products? ___ Yes ___ No For How Long, # packs/day: _____

Do you use controlled substances? ___ Yes ___ No _____

For Women: Are you: ___ Pregnant/Trying to get pregnant? ____Nursing? ____Taking contraceptives? _____

Are you Allergic to any of the following:

____ Aspirin ____ Penicillin ____ Codeine _____ Acrylic ____ Metal ____ Latex ____ Local Anesthetics _____ Other: _____

Do you have, or have you ever had, any of the following conditions:

__AIDS/HIV Positive	__Chest Pains	__Frequent Headaches	__Irregular Heartbeat	__Scarlet Fever
__Alzheimer's Disease	__Cold Sores/Fever Blisters	__Genital Herpes	__Kidney Problems	__Shingles
__Anaphylaxis	__Congenital Heart Disorder	__Glaucoma	__Leukemia	__Sickle Cell Disease
__Anemia	__Convulsions	__Hay Fever	__Liver Disease	__Sinus Trouble
__Angina	__Cortisone Medicine	__Heart Attack/Failure	__Low Blood Pressure	__Spina Bifida
__Arthritis/Gout	__Diabetes	__Heart Murmur	__Lung Disease	__Stomach/Intestinal Disease
__Artificial Heart Valve	__Drug Addiction	__Heart Pace Maker	__Mitral Valve Prolapse	__Stroke
__Asthma	__Emphysema	__Hemophilia	__Parathyroid Disease	__Thyroid Disease
__Blood Disease	__Epilepsy or Seizures	__Hepatitis A	__Psychiatric Care	__Tonsillitis
__Blood Transfusion	__Excessive Bleeding	__Hepatitis B or C	__Radiation Treatments	__Tuberculosis
__Breathing Problem	__Excessive Thirst	__Herpes	__Recent Weight Loss	__Tumors or Growths
__Bruise Easily	__Fainting Spells/Dizziness	__High Blood Pressure	__Renal Dialysis	__Ulcers
__Cancer	__Frequent Cough	__Hives or Rash	__Rheumatic Fever	__Venereal Disease
__Chemotherapy	__Frequent Diarrhea	__Hypoglycemia	__Rheumatism	__Yellow Jaundice

Have you ever had a serious illness not listed above? If Yes, please explain: _____

General Health History Comments: _____

Dental History

When was your last dental exam? _____ When were your last dental x-rays taken? _____

How often do you brush? _____ Times daily How often do you floss? _____ Times daily Type of toothbrush: _____ Manual _____ Electric

Have you ever had braces/orthodontic treatment? ___ Yes ___ No If yes, please explain: _____

Have you ever been treated for periodontal disease? ___ Yes ___ No If yes, when? _____

Have you ever had injuries to your teeth, face or jaw? ___ Yes ___ No If yes, please explain: _____

Do you experience, or have you experienced in the past, any of the following:

__Bad Breath	__Bleeding Gums	__Blisters on Mouth	__Broken Fillings/Teeth	__Clicking Jaw
__Dentures	__Dental Anxiety	__Difficulty Opening/Closing	__Difficulty Chewing	__Dry Mouth
__Ear Pain	__Jaw Pain	__Loose Teeth	__Missing Teeth	__Mouth Sores
__Sensitivity – Cold	__Sensitivity – Hot	__Sensitivity – Sweets	__Sensitivity – Pressure	__Swollen Gums

To the best of my knowledge, the questions on this form have been answered completely and accurately. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform 1st Family Dental of any changes in medical status.

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