NORTHERN FAMILY DENTISTRY

Confidential Medical-Dental History

Patient's Name _____

Birth Date ____ /____ /_____ Soc Sec # _____

Home phone _____ Work phone _____

Cell phone _____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

Medical History

Name of Physician _____ Phone _____

Address _____

Date of last visit _____ Reason for last visit _____

No Yes **Answer the following questions yes or no. If your answer is yes, please explain in the lines provided.**

☐ ☐ 1. Are you currently under the care of a physician?
If yes, for what reason or condition? _____

☐ ☐ 2. Have you ever been hospitalized?
If yes, when? _____ Reason: _____

☐ ☐ 3. Are you currently taking any medication?
If yes, what medication and for what reason or condition? _____

☐ ☐ 4. Have you ever had a serious injury to your head or neck?
If yes, describe: _____

☐ ☐ 5. Are you on a special diet?
If yes, for what reason and describe: _____

☐ ☐ 6. Are there any other problems about your health of which you are aware?
If yes, describe: _____

No **Mark the adjacent box if you have had or been treated for the following, explain. If you haven't, mark the far left box.**

☐ 7. ☐ Rheumatoid fever ☐ Rheumatic heart disease ☐ Heart murmur ☐ Congenital heart disease ☐ Heart valve ☐ Pacemaker ☐ Artificial joint replacement ☐ Med ports _____

☐ 8. ☐ Heart trouble ☐ Angina ☐ Chest pain ☐ Heart surgery ☐ Pacemaker ☐ Irregular heartbeats _____

☐ 9. ☐ Abnormal blood pressure ☐ Excessive bleeding ☐ Anemia _____

☐ 10. ☐ Stroke ☐ Convulsions ☐ Fainting spells _____

☐ 11. For *women*: Are you ☐ Pregnant ☐ Nursing ☐ Taking birth control pills _____

☐ 12. ☐ Cancer ☐ Radiation treatments ☐ Chemotherapy _____

☐ 13. ☐ Diabetes ☐ Excessive urination ☐ Excessive thirst _____

☐ 14. ☐ Hepatitis ☐ Jaundice ☐ Liver disease _____

☐ 15. ☐ Kidney problems ☐ Renal dialysis _____

☐ 16. ☐ Sexually transmitted disease ☐ HIV infection _____

☐ 17. ☐ Glaucoma ☐ Problems with eyesight _____

☐ 18. ☐ Frequent severe headaches _____

☐ 19. ☐ Tumors ☐ Growths _____

☐ 20. ☐ Arthritis ☐ Rheumatism ☐ Painful or swollen joints _____

☐ 21. ☐ Stomach problems ☐ Intestinal problems _____

☐ 22. ☐ A major operation _____

Mark the box if you have had allergic reactions to any of the following:

☐ Aspirin ☐ Sulfonamides ☐ Tetracycline ☐ Iodine ☐ Penicillin ☐ Barbiturates ☐ Codeine ☐ Latex

List other additional allergies: _____

Please Continue on Back

Dental History

Name & date of last dentist seen: Dr _____ Date _____

Reason for your last visit (or series of visits)? _____

No	Yes	Answer yes or no. If yes, explain in the line provided. In respect to any previous dental treatment, have you:
☐	☐	23. Ever fainted? _____
☐	☐	24. Had abnormal bleeding? _____
☐	☐	25. Any other complications during or following dental treatment? _____
		_____
☐	☐	26. Do your gums bleed on brushing or eating? _____
☐	☐	27. Does food catch between your teeth? _____
☐	☐	28. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? _____
		_____
☐	☐	29. Are you satisfied with the appearance of your teeth? _____
☐	☐	30. Do you smoke or use tobacco? _____
☐	☐	31. Would you be disturbed if you lost any of your natural teeth? _____
☐	☐	32. Are any of your teeth sensitive to heat, cold, sweets, or pressure? _____
☐	☐	33. Do you grind your teeth or clench your jaws? _____
☐	☐	34. Do you have pain or clicking in the jaw joint around your ear? _____
☐	☐	35. Do you have herpes, cold sores, sores in or around the mouth? _____
☐	☐	36. Do any of your teeth ache? _____
☐	☐	37. Do you have any other dental complaint? _____
☐	☐	38. Are you worried about receiving dental treatment? _____
☐	☐	39. Have you ever had any unpleasant experiences in a dental office? _____
		_____

Mark the box next to the items you would be interested in learning more about.

☐ Fluorides	☐ Cosmetic dentistry, laminates	☐ Periodontal disease	☐ Sealants
☐ Braces	☐ Replacing missing teeth	☐ X-rays	☐ Implants
☐ TMJ dysfunction	☐ Whitening teeth	☐ Closing gaps in teeth	☐ Claspless partials

Reason for your appointment today: _____

Questions or concerns:

If the question is not understood, you are not certain of the answer, or have any questions, please indicate in the box to the right and discuss with the doctor.

Note: A change in your health status in the future should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered. I grant the right to the dentist to release health information obtained from me, and information about dental treatment to third party payors, and/or health practitioners.

I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Person completing form: Signature _____

Print Name _____

If other than the patient, indicate relationship: _____ Date ___ /____ /_____

Signature Dr _____ Date ___ /____ /_____