Quality Care Dental

is our commitment from us to you!

MEDICAL HISTORY

Patient's Name:_____ Age:_____ Chart #:_____

1. Is patient in good health? ☐ Yes ☐ No If No, explain _____
2. Physician's Name:_____ Phone Number:_____
   Is patient under a physicians care now? ☐ Yes ☐ No If Yes, explain_____
3. Is patient taking prescribed or any over the counter medication? Birth control medications? ☐ Yes ☐ No
   If Yes, list medications: _____
4. Is the patient pregnant?_____ If so, how many months? _____
5. Has patient taken any weight loss medications? (e.g. PhenFen) ☐ Yes ☐ No
6. Has patient ever had a blood transfusion? ☐ Yes ☐ No
7. Does the patient smoke? ☐ Yes ☐ No Use tobacco? ☐ Yes ☐ No Use recreational drugs? ☐ Yes ☐ No
8. Has the patient ever had a allergic reaction to local anesthetic (e.g novacaine)? ☐ Yes ☐ No
9. Is the patient allergic to any medication (e.g. penicillin)? ☐ Yes ☐ No
10. Is the patient allergic to latex? ☐ Yes ☐ No
11. Has the patient ever had prolonged bleeding after an injury or extraction? ☐ Yes ☐ No
12. Does the patient have a cardiac pacemaker or artificial heart valve? ☐ Yes ☐ No
13. Is there any family history of diabetes, heart murmur/problems, tumors? ☐ Yes ☐ No
14. Does the patient's jaw pop or click when chewing? (TMJ) ☐ Yes ☐ No
15. Are you pleased with the appearance of your smile? ☐ Yes ☐ No
    If no, explain _____
16. What would you like to discuss with the dentist today?

☐ Tooth Ache	☐ Oral Surgery	☐ Partials/Dentures	☐ Cosmetic Dentistry
☐ Gum Problem	☐ Routine check-up	☐ Removal of Wisdom Teeth	☐ Crowns/Bridges
☐ Braces	☐ Second Opinion	☐ Replace missing teeth	☐ Other _____

17. Does the patient have any missing teeth? ☐ Yes ☐ No If yes, does the patient have an appliance? ☐ Yes ☐ No
    What type?_____ Year made_____ Is it comfortable? ☐ Yes ☐ No
18. Please check each box, yes or no, if the patient has ever had any illness or conditions listed below. Please do not leave it blank.

Y N	Y N	Y N	Y N
☐ ☐ AIDS/HIV	☐ ☐ Allergies	☐ ☐ Anemia	☐ ☐ Angina
☐ ☐ Arthritis	☐ ☐ Artificial Joint	☐ ☐ Asthma	☐ ☐ Bleeding Disorders
☐ ☐ Cancer	☐ ☐ Chemotherapy	☐ ☐ Cold Sores	☐ ☐ Diabetes
☐ ☐ Dizzy Spells	☐ ☐ Emphysema	☐ ☐ Epilepsy	☐ ☐ Emotional Disorder
☐ ☐ Fainting	☐ ☐ Fever Blisters	☐ ☐ Glaucoma	☐ ☐ Heart Attack
☐ ☐ Heart Bypass	☐ ☐ Heart Murmur	☐ ☐ Heart Problems	☐ ☐ Heart Surgeries
☐ ☐ Hepatitis	☐ ☐ High Blood Pressure	☐ ☐ HIV Positive	☐ ☐ Immunosuppressed
☐ ☐ Jaundice	☐ ☐ Kidney Disease	☐ ☐ Liver Problems	☐ ☐ Low Blood Pressure
☐ ☐ Lung Disease	☐ ☐ Nervous/Mental Disorder	☐ ☐ Psychiatric Treatment	☐ ☐ Radiation Therapy
☐ ☐ Rheumatic Fever	☐ ☐ Sinus Trouble	☐ ☐ Stroke	☐ ☐ Thyroid Problems
☐ ☐ Tuberculosis	☐ ☐ Venereal Disease		

18. Has patient had any disease, serious illness/surgery, condition or problem not listed above. ☐ Yes ☐ No If Yes, explain _____

_____

_____ _____

Patient's Signature/responsible party if patient is a minor Date

For Doctors Use Only

Health History Reviewed By _____(Doctor's Signature) Date_____

Comments:_____

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