MEDICAL DENTAL HISTORY FORM

Name_____ Address _____

Phone _____ DOB _____ Spouse _____

Employer _____ Phone _____ Occupation _____

Physician _____ Phone _____

Date of Last Physical Exam _____ Date of Last Dental Exam _____

DO YOU, OR HAVE YOU EVER, HAD ANY OF THE FOLLOWING?

	YES	NO	UNKNOWN	COMMENTS
Any breathing or respiratory problems?	[ ]	[ ]	[ ]	_____
Asthma? (If yes answer a,b)	[ ]	[ ]	[ ]	_____
a) If yes are you steroid dependent?	[ ]	[ ]	[ ]	_____
b) Do you use an inhaler?	[ ]	[ ]	[ ]	_____
Sinus Problems?	[ ]	[ ]	[ ]	_____
Seasonal allergies or hayfever?	[ ]	[ ]	[ ]	_____
Airway obstructions?	[ ]	[ ]	[ ]	_____
Difficulty with intubation during general anesthesia?	[ ]	[ ]	[ ]	_____
A smoking habit ?	[ ]	[ ]	[ ]	_____
History of TB?	[ ]	[ ]	[ ]	_____
High blood pressure?	[ ]	[ ]	[ ]	_____
Low blood pressure?	[ ]	[ ]	[ ]	_____
Angina?	[ ]	[ ]	[ ]	_____
Heart Attack?	[ ]	[ ]	[ ]	_____
Stroke?	[ ]	[ ]	[ ]	_____
Coronary Artery disease?	[ ]	[ ]	[ ]	_____
Arrhythmias?	[ ]	[ ]	[ ]	_____
Rheumatic Fever	[ ]	[ ]	[ ]	_____
Heart murmur?	[ ]	[ ]	[ ]	_____
Inborn heart defects?	[ ]	[ ]	[ ]	_____
Mitral Valve prolapse?	[ ]	[ ]	[ ]	_____
Artificial Heart Valves?	[ ]	[ ]	[ ]	_____
Pacemaker? (If yes, answer a)	[ ]	[ ]	[ ]	_____
a) Should electronic devices be avoided?	[ ]	[ ]	[ ]	_____
Heart Surgery?	[ ]	[ ]	[ ]	_____
Do you require antibiotics before dental treatment?	[ ]	[ ]	[ ]	_____
Blood dyscrasias?	[ ]	[ ]	[ ]	_____
Sickle Cell anemia?	[ ]	[ ]	[ ]	_____
Thyroid problems?	[ ]	[ ]	[ ]	_____
Diabetes? (If yes answer a-c)	[ ]	[ ]	[ ]	_____
a) If diabetic are you on insulin?	[ ]	[ ]	[ ]	_____
b) If diabetic are you well controlled?	[ ]	[ ]	[ ]	_____
c) If diabetic are you on oral medications?	[ ]	[ ]	[ ]	_____
Liver Disease?	[ ]	[ ]	[ ]	_____
Hepatitis A ?	[ ]	[ ]	[ ]	_____
Hepatitis B ?	[ ]	[ ]	[ ]	_____
Hepatitis C ?	[ ]	[ ]	[ ]	_____
Stomach or duodenal ulcer?	[ ]	[ ]	[ ]	_____
GERD (Gastro Esophageal Reflux Disease)	[ ]	[ ]	[ ]	_____
Colitis ?	[ ]	[ ]	[ ]	_____
Kidney disease?	[ ]	[ ]	[ ]	_____
Kidney stones ?	[ ]	[ ]	[ ]	_____
Glaucoma ?	[ ]	[ ]	[ ]	_____

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	YES	NO	UNKNOWN	COMMENTS
Cancer ? (If yes please answer a-d).....	[ ]	[ ]	[ ]	_____
a) What type of cancer did you have?.....	[ ]	[ ]	[ ]	_____
b) Chemotherapy ?.....	[ ]	[ ]	[ ]	_____
c) Radiation ?.....	[ ]	[ ]	[ ]	_____
d) Other treatment for cancer ?.....	[ ]	[ ]	[ ]	_____
Facial or Jaw trauma?.....	[ ]	[ ]	[ ]	_____
Scoliosis?.....	[ ]	[ ]	[ ]	_____
Bone, joint or muscular problems?.....	[ ]	[ ]	[ ]	_____
Artificial joints or surgically placed prosthesis?.....	[ ]	[ ]	[ ]	_____
Arthritis ?.....	[ ]	[ ]	[ ]	_____
If yes, how long?.....	[ ]	[ ]	[ ]	_____
Any problems with local anesthesia ?.....	[ ]	[ ]	[ ]	_____
Fainting with local anesthesia?.....	[ ]	[ ]	[ ]	_____
Allergy to local anesthesia ? If so, what happened?.....	[ ]	[ ]	[ ]	_____
Difficulty getting numb ?.....	[ ]	[ ]	[ ]	_____
History of paresthesia ?.....	[ ]	[ ]	[ ]	_____
Neurological Disorders?.....	[ ]	[ ]	[ ]	_____
Epilepsy?.....	[ ]	[ ]	[ ]	_____
Mental or emotional problems ?.....	[ ]	[ ]	[ ]	_____
Alcohol or substance abuse?.....	[ ]	[ ]	[ ]	_____
Dental				
Are you experiencing pain from your mouth at this time?.....	[ ]	[ ]	[ ]	_____
Do your gums bleed? When?.....	[ ]	[ ]	[ ]	_____
Have you ever has an acute sore mouth or "trench" mouth?	[ ]	[ ]	[ ]	_____
Are you aware of a bad taste or odor in your mouth?.....	[ ]	[ ]	[ ]	_____
Are you troubled with frequent "gum boils"?.....	[ ]	[ ]	[ ]	_____
Cold Sores?.....	[ ]	[ ]	[ ]	_____
Oral Herpes?.....	[ ]	[ ]	[ ]	_____
Xerostomia (dry mouth)?.....	[ ]	[ ]	[ ]	_____
Did either your mother, father, brother or sister lose all their natural teeth?.....	[ ]	[ ]	[ ]	_____
Are you satisfied with the appearance of your teeth?.....	[ ]	[ ]	[ ]	_____
Have you ever had a severe toothache?.....	[ ]	[ ]	[ ]	_____
Are you bothered by tooth sensitivity? Hot, cold, sweets?..	[ ]	[ ]	[ ]	_____
Does food catch between your teeth?.....	[ ]	[ ]	[ ]	_____
Do tartar and stain return quickly?.....	[ ]	[ ]	[ ]	_____
Do cavities develop rapidly?.....	[ ]	[ ]	[ ]	_____
Can you chew satisfactorily?.....	[ ]	[ ]	[ ]	_____
Do you chew on both sides of your mouth?.....	[ ]	[ ]	[ ]	_____
Do you have any particular mouth habits? Lip, cheek or tongue biting, foreign objects between teeth, etc.?.....	[ ]	[ ]	[ ]	_____
Are you conscious of any habit with your tongue?.....	[ ]	[ ]	[ ]	_____
Do you clench or grind your teeth?.....	[ ]	[ ]	[ ]	_____
Do you awaken in the morning with your teeth together, tired jaws, numb feeling in your teeth or pain in your jaw?.	[ ]	[ ]	[ ]	_____
Do your teeth come together evenly?.....	[ ]	[ ]	[ ]	_____
Are you conscious of sore, loose or shifting teeth?.....	[ ]	[ ]	[ ]	_____
Are you conscious of any high or rough teeth or fillings?.....	[ ]	[ ]	[ ]	_____
Do you ever have pain opening or closing your mouth?.....	[ ]	[ ]	[ ]	_____
Does your jaw ever go, "out of joint"?.....	[ ]	[ ]	[ ]	_____
Have you ever had any teeth removed?.....	[ ]	[ ]	[ ]	_____
Did you have the missing tooth or teeth replaced?.....	[ ]	[ ]	[ ]	_____

MEDICAL DENTAL HISTORY FORM

	YES	NO	UNKNOWN	COMMENTS
Allergies				
Allergy to latex ?……	[ ]	[ ]	[ ]	_____
Allergy to nickel, acrylic or other ?……	[ ]	[ ]	[ ]	_____
Allergic to any medications or foods? (If yes please list)…	[ ]	[ ]	[ ]	_____
Female Patients only:				
Pregnant ?……	[ ]	[ ]	[ ]	_____
Taking birth control pills?……	[ ]	[ ]	[ ]	_____
HIV positive?……	[ ]	[ ]	[ ]	_____
Have you had any infections in the last 2 weeks?……	[ ]	[ ]	[ ]	_____
Do you have any medical problems not mentioned above? (Please list)……	[ ]	[ ]	[ ]	_____

Please list all prescription and non-prescription medications, and herbal products that you are presently taking:

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have there been any medications that you have had to stop because you experienced side effects?

_____

_____

_____

TO BE COMPLETED BY DENTIST:
Dental Implications Regarding Medication / Dental History:

_____

_____

_____

Do any of the above medications effect the QT interval?

_____

_____

Dentist's Signature _____

Name (printed) _____ **Date** _____

For Use by DDS (notes)

Patient's Signature _____

Developed through the OPWDD New York State Dental Task Force on Special Dentistry with the assistance of Dr. Steven G.Messing, Diplomate, American Board of Orafacial Pain.