Greater Family Health

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Dental – Medical History

Patient Name: ____ Date of Birth: ______________________

Person completing this form (if other than the patient): ____________________________ Relationship: _____________

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

What is the main reason for your visit today? ____

Please circle the appropriate answer.

Are you allergic to any food or medications? YES NO If yes, please explain: ______________________

Have you been pre-medicated before any dental procedures? YES NO If yes, please explain: _______________

Are you taking any medications? This includes prescribed, over the counter and herbal medications.

YES NO If yes, please list:

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Do you have, or have you had, any of the following?

ADHD	YES	NO	Heart Disease	YES	NO
AIDS/ HIV positive	YES	NO	Heart murmur	YES	NO
Artificial heart valve	YES	NO	Heart pacemaker	YES	NO
Artificial joint	YES	NO	Hepatitis	YES	NO
Bleeding Disorder	YES	NO	High blood pressure	YES	NO
Bulimia	YES	NO	Mitral valve prolapse	YES	NO
Cancer	YES	NO	Osteoporosis	YES	NO
Developmental problems	YES	NO	Pregnancy	YES	NO
Diabetes	YES	NO	Tobacco use	YES	NO
Epilepsy or Seizures	YES	NO	tuberculosis	YES	NO

For female patients:

Are you pregnant? YES NO Are you nursing? YES NO Are you taking oral contraceptives? YES NO

Have you ever had any serious illness not listed on this form? YES NO If yes, Please explain:

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Additional Comments:____

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