AIDC DENTAL PATIENT MEDICAL HISTORY

Please answer all questions and sign/date at the bottom of the page.
If you are unsure of how to answer any of the following questions, please ask the dental staff for help.

How did you find out about this dental clinic? ____________________

What is the reason for your visit to the dental clinic? ____________________

What is the name of your medical doctor? ____________________

What is the date of your last physical examination? ____________________

Has there been any change in your general health this year? Yes ☐ No ☐ Explain:
____

List any medications (pills or drugs) that you are taking: ____________________

Patient General Health ☐ Good ☐ Fair ☐ Poor

Gender ☐ Male ☐ Female

Please check your answers

		YES	NO
1.	Do you have a toothache?	☐	☐
2.	Have you received medical care within the past two years? Why / When? ____________	☐	☐
3.	Have you ever been hospitalized? Why / When? ____________	☐	☐
4.	Have you taken medications in the last two months? What? ____________	☐	☐
5.	Are you allergic to or made sick by any medicine such as penicillin, aspirin, codeine, or sulfur? Other ____________	☐	☐
6.	Have you ever had a bleeding problem that needed medical treatment?	☐	☐
7.	Do you have chest pain?	☐	☐
8.	Do you use alcohol or drugs?	☐	☐
9.	Do you use tobacco products?	☐	☐
10.	Do you have reason to believe you might have_AIDS, Herpes, or HIV (+)?	☐	☐
11.	Do you have diabetes?	☐	☐
12.	Does anyone in your family have diabetes? Who? (mom, dad) ____________	☐	☐
13.	Do you play sports?	☐	☐
14.	Do you have any concerns about receiving dental treatments? Explain: ____________	☐	☐

Do you have any disease or condition not listed? Yes ☐ No ☐
Explain: ____________________

Have you ever had any of the following

		YES	NO
1.	Hepatitis	☐	☐
2.	Heart Murmur	☐	☐
3.	Heart Attack or Heart Trouble	☐	☐
4.	High blood pressure	☐	☐
5.	Rheumatic fever	☐	☐
6.	Heart valve or pace maker, heart surgery	☐	☐
	If yes, does the patient require medication for dental appointments?	☐	☐
7.	Artificial joint	☐	☐
8.	Anemia	☐	☐
9.	Stroke	☐	☐
10.	Ulcers	☐	☐
11.	TB or lung disease	☐	☐
12.	Asthma	☐	☐
13.	Sinus trouble	☐	☐
14.	Cancer or tumor	☐	☐
15.	Epilepsy or seizures	☐	☐
16.	Arthritis / Rheumatism (including juvenile)	☐	☐
17.	Blood transfusion, Hemophilia	☐	☐
18.	Sexually transmitted disease	☐	☐
19.	Kidney problems	☐	☐
20.	Liver problems	☐	☐
21.	Nervous or mental disorder, emotional problems, hyperactivity	☐	☐

FEMALES ONLY – Are you:

		YES	NO
1.	Pregnant?	☐	☐
2.	Taking birth control pills?	☐	☐
3.	Currently nursing?	☐	☐

PATIENT IDENTIFICATION:

The answers I have given are true to the best of my knowledge. **I am giving my consent for routine dental procedures such as x-rays, cleaning, fillings, crowns, and local anesthesia by signing below.**

____________________ Date: ____________
Patient or Parental Consent (Signature)

____________________ Date: ____________
Dentist (Signature)

Approved 04/08