AIDC DENTAL PATIENT MEDICAL HISTORY

Please answer all questions. Sign and 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 medical appointment? _____
Has there been any change in your general health this year? Yes _____ No _____ Explain: _____
List any medications you currently take with dosages (including those you may have purchased without a prescription and/or any herbal remedies that you take):_____
_____

Patient General Health: ☐ Good ☐ Fair ☐ Poor Gender: ☐ Male ☐ Female

Please check your answers	YES	NO	Have you ever had any of the following	YES	NO
1. Do you have a toothache?			1. Hepatitis What kind? A B C Other Treated or Active? (circle one)		
2. Have you received medical care within the past two years? Why/When?			2. Heart murmur		
3. Have you ever been hospitalized? Why/When?			3. Heart attack or heart trouble		
			4. High blood pressure		
4. Have you taken medications in the last 2 months? What?			5. Rheumatic fever		
			6. Heart valve or pace maker, heart surgery If yes, does the patient require medication for dental appointments?		
5. Are you allergic to or made sick by any medicine such as penicillin, aspirin, codeine, or sulfur? Other?			7. Artificial joint		
			8. Anemia		
			9. Stroke		
6. Are you allergic to latex, iodine, red dye, metal and/or local anesthetic?			10. Ulcers		
			11. Liver problems		
7. Have you ever had a bleeding problem that needed medical treatment?			12. Tuberculosis – Currently or in past (circle)		
8. Do you have chest pain?			13. Respiratory or breathing disorders? If yes, please explain:		
9. Do you use alcohol or drugs?					
10.Do you use tobacco products, incl. e-cigarettes?			14. Asthma		
If yes, are you interested in quiting?			15. Sinus trouble		
11.Do you have reason to believe you might have HIV/AIDS or herpes?			16. Epilepsy or seizures		
			17. Cancer or tumor – Dates:		
12. Diabetes? Type 1 or Type 2 (circle one)			18. Chemotherapy and/or radiation -- Dates:		
13. Does anyone in your family have diabetes? Who? (mom, dad)			19. Arthritis / Rheumatism (including juvenile)		
			20. Lupus		
			21. Blood transfusion, hemophilia		
14. Do you play sports?			22. Sexually transmitted disease		
15. Do you have concerns about receiving dental treatments? Explain:			23. Kidney problems/dialysis		
			24. Nervous or mental disorder, emotional problems, hyperactivity		
16. Do you have any physical or mental disability that requires special considerations? Explain:			25. Osteoporosis If yes, do you take any medication?		
17. *Females only			26. Do you have any condition not listed? Explain:		
Taking birth control?					
Pregnant?					
Currently breastfeeding?					

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/or local anesthesia by signing below:

_____
Patient signature (or Parent/Guardian if patient is a minor) Date

_____
Dentist signature Date

Approved 05/2018