# ENCINO FAMILY DENTISTRY
COSMETIC & IMPLANT CENTER

| Indicate type of service | |
|---|---|
| Extraction | |
| Cleaning | |

# Dental Medical History Form

## 1. Patient Information

| | | | | |
|---|---|---|---|---|
| **Date of Birth:** | Month: | Day: | Year: | |
| **Legal Name:** | **First:** | | **MI:** | **Last:** |
| | Preferred Name: | | | |

## 2. Important Information For Your Dentist

1. List any allergies: _____
2. List any prescribed medications you are currently taking: _____
3. List any over-the-counter medications/vitamins you are taking: _____
4. List any previous reactions to local anesthetic, metals, or sedation: _____
5. List any illnesses/surgeries/hospitalizations: _____
6. Is pre-medication required before dental visits? ☐ Yes ☐ No
7. List any use of recreational drugs: _____

## 3. Primary Care Information

Physician: | Telephone Number: | Clinic/Facility:

**All Patients:** Do you have, or have you ever had any of the following? (Check all that apply) ☐ NONE

| | | | |
|---|---|---|---|
| ☐ Abnormal Blood Pressure | ☐ Chemical Dependency | ☐ Heart Pacemaker | ☐ Prosthetic Implants |
| ☐ Alcohol Addiction | ☐ Chemotherapy | ☐ Hemophilia | ☐ Psychiatric Care |
| ☐ AIDS/HIV | ☐ Congenital Heart Disease | ☐ Hepatitis ☐A☐B☐C | ☐ Radiation Therapy |
| ☐ Anemia | ☐ Diabetes | ☐ Kidney Problems | ☐ Rheumatic Fever |
| ☐ Anorexia | ☐ Recreational Drugs | ☐ Learning Disability | ☐ Rheumatic Heart Disease |
| ☐ Artificial Heart Valve | ☐ Emphysema | ☐ Mitral Valve Prolapse | ☐ Sickle Cell Disease |
| ☐ Artificial Joint | ☐ Epilepsy/Seizures | ☐ Neurological Disorders | ☐ Sinus Trouble |
| ☐ Asthma/Breathing Issues | ☐ Fainting Spells | ☐ Organ Transplant | ☐ Stroke |
| ☐ Bulimia | ☐ Hearing Problems | ☐ Pregnant/Nursing | ☐ Tuberculosis |
| ☐ Cancer/Malignancy | ☐ Heart Disease/Surgery | ☐ Prolonged Bleeding | |

## 4. Dental History

| | |
|---|---|
| **Rate Your Oral Health:** | ☐ Excellent ☐ Good ☐ Fair ☐ Poor |
| **Date of Last Dental Visit:** _____ | **Treatment Type:** |

☐ **Y /** ☐ **N** Do you feel pain to any of your teeth? Hot/Cold/Sweet/Sour/Sensitivities. Pain when chewing?
☐ **Y /** ☐ **N** Do you have sores or lumps in or near your mouth?
☐ **Y /** ☐ **N** Have you had any head, neck or jaw injuries?
☐ **Y /** ☐ **N** Do you bite your lips or cheeks frequently?
☐ **Y /** ☐ **N** Have you ever experienced any of the following?
☐ Clicking in jaw ☐ Pain (joint, ear, side of face) ☐ Difficulty in opening or closing mouth ☐ Difficulty chewing
☐ **Y /** ☐ **N** Have you ever had prolonged bleeding following extractions?
☐ **Y /** ☐ **N** Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc)
☐ **Y /** ☐ **N** Any unusual speech habits? If yes, explain: _____

| | | | |
|---|---|---|---|
| Any other dental concerns? | | | |
| Patient/Guardian Signature: | | Date: | |
| Dentist Signature: | | Date: | |