**Dental Medical History Form**

**Patient Information:**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Are you currently under the care of a physician? Yes / No

If yes, please provide the physician's name and contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any known allergies? Yes / No

If yes, please specify the allergies and the reaction(s) experienced: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following medical conditions?

Heart disease Yes / No

High blood pressure Yes / No

Diabetes Yes / No

Asthma Yes / No

Rheumatic fever Yes / No

Epilepsy or seizures Yes / No

Kidney disease Yes / No

Liver disease Yes / No

Thyroid disease Yes / No

HIV/AIDS Yes / No

Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications? Yes / No

If yes, please list the medications and their dosages:

Have you ever had any adverse reactions or complications to dental treatment or anesthesia? Yes / No

If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**:

Date of your last dental visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience dental anxiety or fear? Yes / No

**Have you ever been diagnosed with or treated for any of the following dental conditions?**

Cavities Yes / No

Gum disease Yes / No

TMJ disorder Yes / No

Tooth sensitivity Yes / No

Dental implants Yes / No

Orthodontic treatment Yes / No

Oral surgery/extractions Yes / No

Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any complications or adverse reactions to dental treatment? Yes / No

If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information:**

Please provide any additional information that you think is relevant or that the dentist should be aware of:

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_