Healy & Molinaro
Family Practice Dentistry

Dental and Medical History Form

Patient name: | Birth date: | Date created:

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

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills or drugs?	Yes No	If yes	
Do you take, or have you taken Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphos-phoantes?	Yes No	If yes	
Are you on a special diet?	Yes No	If yes	
Do you use tobacco?	Yes No	If yes	
Do you use controlled substances?	Yes No	If yes	

Women: Are you...

Pregnant/Trying to get pregnant? | Nursing? | Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin | Penicillin | Codeine | Acrylic

Metal | Latex | Sulfa Drugs | Local Anesthetics

Other allergies? | If yes

Have you travelled outside the country in the past 3 months? Yes No If yes

Dental History

Reason for today's visit		Comment	
Date of last dental care		Comment	
Date of last x-rays		Comment	
Previous Dentist		Comment	
Previous Dentist, Address, Phone Number		Comment	

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Have you experienced any of the following?

Bad breath	Yes	No	Sensitivity to cold	Yes	No
Grinding teeth	Yes	No	Food collects between teeth	Yes	No
Sensitivity to heat	Yes	No	Herpes/cold sores	Yes	No
Bleeding gums	Yes	No	Sensitivity when biting	Yes	No
Loose teeth	Yes	No	Clinching teeth	Yes	No
Sensitivity to sweets	Yes	No	Sores in mouth	Yes	No
Clicking or popping jaw	Yes	No	Growths in mouth	Yes	No
Periodontal treatment	Yes	No			

How often do you floss?

How often do you brush?

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

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive			Cortisone medicine			Hemophilia			Radiation treatments		
Alzheimer's Disease			Diabetes			Hepatitis A			Recent weight loss		
Anaphylaxis			Drug addiction			Hepatitis B or C			Renal dialysis		
Anemia			Easily winded			Herpes			Rheumatic fever		
Angina			Emphysema			High blood pressure			Rheumatism		
Arthritis/Gout			Epilepsy or seizures			High cholesterol			Scarlet fever		
Artificial Heart Valve			Excessive bleeding			Hives or rash			Shingles		
Artificial Joint			Excessive thirst			Hypoglycemia			Sickle cell disease		
Asthma			Fainting spells/dizziness			Irregular heartbeat			Sinus trouble		
Blood Disease			Frequent cough			Kidney problems			Spina Bifida		
Blood transfusion			Frequent diarrhea			Leukemia			Stomach/intestinal disease		
Breathing problems			Frequent headaches			Liver disease			Stroke		
Bruise easily			Genital herpes			Low blood pressure			Swelling of limbs		
Cancer			Glaucoma			Lung disease			Thyroid disease		
Chemotherapy			Hay fever			Mitral valve prelapse			Tonsilitis		
Chest pains			Heart attack/failure			Osteoporosis			Tuberculosis		
Heart murmer			Pain in jaw joints			Tumors or growths			Congenital heart disorder		
Heart Pacemaker			Parathyroid disease			Ulcers			Convulsions		
Heart trouble/disease			Psychiatric care			Venereal disease			Yellow Jaundice		

Have you ever had any serious illness not listed above? Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X _____ Date: _____