Dental History Adult & Child

To meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history.

Name: (Last) _____ (First) _____ (MI) _____ Date of Birth: _____ Age: _____

Do you have an Optometrist (Eye Doctor): ___ YES ___ NO
Do you have a Therapist/Counselor: ___ YES ___ NO
Do you have a Primary Medical Provider (Family Doctor): ___ YES ___NO

1. PAST MEDICAL HISTORY: Have you ever had the following: ____ Patient denies any illnesses

Condition	Date	Condition	Date	Condition	Date
Anemia		Asthma		Epilepsy	
Diabetes		Rheumatic Fever		Hypertension	
Heart Disease		Kidney Disease		Hepatitis	
Bone Disease		HIV		Other	

2. PAST SURGICAL HISTORY : Have you ever had the following: ____ Patient denies any surgeries

Surgery	Date	Surgery	Date	Surgery	Date
Pacemaker		Joint Replacement		Oral Surgery	
Bone Fracture		Back Surgery		Other	

3. MEDICATIONS: Please list ALL medications you are currently taking. ____ Patient denies any medications

Name of Medication	Dosage (mg)	How Often

4. ALLERGIES: Please list ALL allergies (food, drugs, and environment) ____ Patient denies any allergies

Allergen	Reaction
Latex Gloves	
Other	

5. FAMILY HISTORY: Has any blood relative had the following: ____ Patient denies any family history

Condition	Relationship	Condition	Relationship	Condition	Relationship
Cancer		Heart Disease		Hypertension	
Diabetes		Anesthesia		Other	

6. SOCIAL HISTORY: ____ Patient denies any social history

Tobacco: ____ Never ____ Minimal ____ Yes (____ packs/day for ____ years) ____ Quit ____years ago

Alcohol: ____ Never ____ Minimal ____ Yes (____ less than 10 drinks per week ____ more than 10 drinks per week)

Recreational Drugs: ____ Never ____ Minimal ____ Yes Type: _____

Printed name of person completing this form: _____Relationship to patient: _____

Signature: _____ Date: _____