MEDICAL AND DENTAL HISTORY

Patient Name: _____ Date of Birth: _____

Address: _____

Why are you here today? _____

Are you having pain or discomfort at this time? ☐ Yes ☐ No

If yes, what type and where? _____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

Medical Doctor's Name: _____

Address: _____

Telephone: _____

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

Are you now taking any medication, drugs, or pills? ☐ Yes ☐ No

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? ☐ Yes ☐ No

If yes, please list: _____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Do you use more than two pillows to sleep? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Do you ever wake up from sleep and feel short of breath? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

If yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? ☐ Yes ☐ No

If yes, how often and how much? _____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? ☐ Yes ☐ No

Do you have or have you had any disease, or condition not listed? ☐Yes ☐No

If yes, please list: _____

Indicate which of the following your have had, or have at present. Circle "Yes" or "No" for each item.

Heart Disease or Attack	☐Yes	☐No	Stroke	☐Yes	☐No	Hepatitis C	☐Yes	☐No
Heart Failure	☐Yes	☐No	Kidney Trouble	☐Yes	☐No	Arteriosclerosis (hardening of arteries)	☐Yes	☐No
Angina Pectoris	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Ulcers	☐Yes	☐No
Congenital Heart Disease	☐Yes	☐No	Venereal Disease	☐Yes	☐No	AIDS	☐Yes	☐No
Diabetes	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Blood Transfusion	☐Yes	☐No
HIV Positive	☐Yes	☐No	Glaucoma	☐Yes	☐No	Cold sores/Fever blisters/ Herpes	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Cortisone Medication	☐Yes	☐No	Artificial Heart Valve	☐Yes	☐No
Mitral Valve Prolapse	☐Yes	☐No	Cosmetic Surgery	☐Yes	☐No	Heart Pacemaker	☐Yes	☐No
Emphysema	☐Yes	☐No	Anemia	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No
Chronic Cough	☐Yes	☐No	Heart Surgery	☐Yes	☐No	Asthma	☐Yes	☐No
Tuberculosis	☐Yes	☐No	Bruise Easily	☐Yes	☐No	Yellow Jaundice	☐Yes	☐No
Liver Disease	☐Yes	☐No	Rheumatic fever	☐Yes	☐No	Rheumatism	☐Yes	☐No
Arthritis	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No	Fainting or Dizzy Spells	☐Yes	☐No
Allergies or Hives	☐Yes	☐No	Nervousness	☐Yes	☐No	Chemotherapy	☐Yes	☐No
Sinus Trouble	☐Yes	☐No	Radiation Therapy	☐Yes	☐No	Drug Addiction	☐Yes	☐No
Pain in Jaw Joints	☐Yes	☐No	Thyroid Problems	☐Yes	☐No	Psychiatric Treatment	☐Yes	☐No
Hay Fever	☐Yes	☐No	Hepatitis A (infectious)	☐Yes	☐No			
Artificial Joints (Hip, Knee, etc.)	☐Yes	☐No	Hepatitis B (serum)	☐Yes	☐No			

For Women Only:

Are you pregnant? ☐Yes ☐No

If yes, what month? _____

Are you nursing? ☐Yes ☐No

Are you taking birth control pills? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

Review Date	Changes in Health Status	Patient's signature	Dentist's signature

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and