Hannibal Dental Group

Patient 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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Has there been any changes in your general health within the past 2 years? ◯ Yes ◯ No If yes

Are you under a physician's care now? ◯ Yes ◯ No

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes

Have you ever taken Fosamax, Boniva, Actonel, Prolia or any other bisphosphonates medications? ◯ Yes ◯ No If yes

Are you on a blood thinner? ◯ Yes ◯ No If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Local Anesthetics

Other? (Not listed above) ◯ Yes ◯ No If yes

Do you use controlled substances? ◯ Yes ◯ No If yes

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

Blood Disorders ◯ Yes ◯ No	Heart Attack ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Epilepsy ◯ Yes ◯ No
Excessive Bleeding ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Heart Pacemaker/Defibulator ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Artificial Joints ◯ Yes ◯ No
COPD ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	AIDS/HIV Positive ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No
Sinus Trouble ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No
Tuberculosis ◯ Yes ◯ No	Tumors/Growths ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Hepatitis A, B, or C ◯ Yes ◯ No
Herpes/Cold Sores/Fever Blisters ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Kidney/Urinary Problems ◯ Yes ◯ No	Sexually Transmitted Disease/HPV ◯ Yes ◯ No
Angina/Chest Pains ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No
Heart Trouble/Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No	

Any serious illness not listed above? ◯ Yes ◯ No If yes

Do you grind or clench your teeth? ◯ Yes ◯ No

Do you have jaw pain? ◯ Yes ◯ No

Do you have bleeding gums? ◯ Yes ◯ No

Do you like your smile? ◯ Yes ◯ No

Ever had an unpleasant dental experience? ◯ Yes ◯ No

Comments:

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:_____