

New Patient Medical History

1st Family Dental www.1fd.org

Date: _____

Have you been hospitalized or had a major operation? Are you var had a serious head/neck injury? Are you taking any medications/pills/drugs? Yes No If Yes, Please Explain: Have you var hospitalized or had a major operation? Yes No If Yes, Please Explain: Have you taken, or do you take, Phen-Fer or Redux? Yes No Our yes boaked products? Yes No Por How Long, # packs/day: Do you use controlled substances? Yes No For How Long, # packs/day: Do you use controlled substances? Yes No For How Long, # packs/day: Do you use controlled substances? Are you Allergic to any of the following: Aspirin Penicillin Codeline Acrylic Metal Latex Local Anesthetics Other: Aspirin Penicillin Codeline Acrylic Metal Latex Local Anesthetics Other: Do you have, or have you ever had, any of the following conditions: AlDS/HIV Positive Chest Pains Frequent Headaches Irregular Heartbeat Scarlet Fever Anemia Convulsions Conjuntal Heart Disorder Glaucoma Leukemia Sickle Cell Disease Anaphylaxis Congenital Heart Disorder Glaucoma Leukemia Sickle Cell Disease Anaphylaxis Congenital Heart Disorder Hay Fever Liver Disease Sinus Trouble Anthritis/Gout Diabetes Heart Murmur Low Blood Pressure Spina Bifida Arthritis/Gout Diabetes Heart Murmur Low Blood Pressure Spina Bifida Arthritis/Gout Diabetes Heart Murmur Low Blood Pressure Spina Bifida Stroke Asthma Emphysema Henophilis Parathrytoid Disease Sinoach/Intestinal Disease Biood Disease Epilepsy or Seizures Hepatitis A Psychiatric Care Tonsillinis Bieding Problem Excessive Thirist Herpes Real Dialysis Ulcers Tonsillinis Bieding Problem Excessive Thirist Herpes Real Dialysis Ulcers Veneraal Disease Trequent Diarrhea Hypoglycemia Rheumatism Yellow Jaundice Dental History Men was your last dental exam? Poental History Men was your last dental exam? How often do you brush? Times daily How often do you floss? Frequent Diarrhea Hypoglycemia Rheumatism Yellow Jaundice Dental Hospory When were your last dental exams Allerdia Disease Propried and Islances Propring/Closing Dyfficulty Ch	Patient Name:		Date of Birth:	Gender:	Age:
Are you under a physician's care now? Yes No If Yes, Please Explain:	problems you may have,	or medications you may be taking	g, could have an important inte		
Jave you ver had a major operation?			General Medical Histo	ory	
Are you Allergic to any of the following: Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other: Do you have, or have you ever had, any of the following conditions: AIDS/HIV Positive Chest Pains Frequent Headaches Irregular Heartbeat Scarlet Fever Alzheimer's Disease Cold Sores/Fever Blisters Genital Herpes Kidney Problems Shingles Anaphytaxis Congenital Heart Disorder Glaucoma Leukemia Sickle Cell Disease Anemia Convulsions Hay Fever Liver Disease Sinus Trouble Angina Cortisone Medicine Heart Attack/Failure Low Blood Pressure Spina Blifida Arthritis/Gout Diabetes Heart Murmur Lung Disease Stomach/Intestinal Disorder Artificial Heart Valve Drug Addiction Heart Pace Maker Mitral Valve Prolapse Stroke Asthma Emphysema Hemophilia Parathyroid Disease Thyroid Disease Blood Disease Epilepsy or Seizures Hepatitis A Psychatric Care Tonsillitis Blood Transfusion Excessive Bleeding Hepatitis B or C Radiation Treatments Tuberculosis Bleeding Problem Excessive Thirst Herpes Recent Weight Loss Tumors or Growths Brusise Easily Fainting Spells/Dizziness High Blood Pressure Renal Dialysis Ulcers Cancer Frequent Cough Hives or Rash Rheumatis Fever Venereal Disease Cancer Frequent Diarrhea Hypoglycemia Rheumatism Yellow Jaundice Have you ever had a serious illness not listed above? If Yes, please explain: Dental History Comments: Dental History When were your last dental x-rays taken? Manual Electr Have you ever had a serious illness not listed above? Yes No If yes, please explain: Manual Electr Have you ever had a procontrodontic treatment? Yes No If yes, please explain: Manual Electr Have you ever had braces/orthodontic treatment? Yes No If yes, please explain: Denture D	Have you been hospitaliz Have you ever had a seri Are you taking any medic Have you been hospitaliz Have you taken, or do yo Are you on a special diet Do you use tobacco prod Do you use controlled su	ted or had a major operation? ous head/neck injury? cations/pills/drugs? ded or had a major operation? u take, Phen-Fen or Redux? utake, Phen-Fen or Redux?	Yes No If Yes, Ple Yes No Yes No Yes No For How Yes Yes No	ease Explain:ease Explain:ease List:ease Explain:ease Expla	
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other: Do you have, or have you ever had, any of the following conditions: AIDS/HIV Positive Chest Pains Frequent Headaches Irregular Heartbeat Scarlet Fever Anaphylaxis Congenital Heart Disorder Glaucoma Leukemia Sickle Cell Disease Anaphylaxis Congenital Heart Disorder Heart Attack/Failure Low Blood Pressure Spina Biffida Arthritis/Gout Diabetes Heart Murmur Lung Disease Strowach/Intestinal Disease Asthma Emphysema Hemophilia Parathyroid Disease Epilepsy or Seizures Hepatitis A Psychiatric Care Tonsillitis Blood Disease Epilepsy or Seizures Hepatitis B or C Radiation Treatments Tuberculosis Bleeding Problem Excessive Thirst Herpes Recent Weight Loss Tumors or Growths Bruise Easily Fainting Spelis/Dizziness High Blood Pressure Renal Dialysis Ulcers Cancer Frequent Cough Hives or Rash Rheumatic Fever Venereal Disease Chemotherapy Frequent Diarrhea Hypoglycemia Rheumatism Yellow Jaundice Dental History When was your last dental exam? How often do you floss? Times daily Type of toothbrush: Manual Electr Have you ever had a serious illness not listed above? If Yes, please explain: Dental History When was your last dental exam? When were your last dental x-rays taken? Have you ever head braces/orthodontic treatment? Yes No If yes, please explain: Dental History Comments: Dental History When were your last dental exam? Manual Electr Have you ever head braces/orthodontic treatment? Yes No If yes, please explain: Dental History Comments: Dental History Difficulty Opening/Closing Difficulty Chewing Dry Mouth	For Women: Are you: _	Pregnant/Trying to get pregnar	nt?Nursing?Takir	ig contraceptives?	
AIDS/HIV Positive Chest Pains Frequent Headaches (Irregular Heartbeat Scarlet Fever Alzheimer's Disease Cold Sores/Fever Blisters Genital Herpes Kidney Problems Shingles Anaphylaxis Congenital Heart Disorder (Glaucoma Leukemia Sickle Cell Disease Anaphylaxis Condental Heart Disorder Hay Fever Liver Disease Sinus Trouble Angina Cortisone Medicine Heart Attack/Failure Low Blood Pressure Spina Bifida Arthritis/Gout Diabetes Heart Murmur Lung Disease Stomach/Intestinal Dise Arthritis/Heart Valve Drug Addiction Heart Pace Maker Mitral Valve Prolapse Stroke Asthma Emphysema Hemophilia Parathyroid Disease Thyroid Disease Blood Disease Epilepsy or Seizures Hepatitis A Psychiatric Care Tonsillitis Blood Transfusion Excessive Bleeding Hepatitis B or C Radiation Treatments Tuberculosis Bliedding Problem Excessive Thirst Herpes Recent Weight Loss Tumors or Growths Ulcers Cancer Frequent Cough Hives or Rash Rheumatic Fever Venereal Disease Prequent Diarrhea Hypoglycemia Rheumatism Yellow Jaundice Dental History When were your last dental x-rays taken? When were you ever had a serious illness not listed above? If Yes, please explain: Manual Electr Have you ever had braces/orthodontic treatment? Yes No If yes, please explain: Manual Electr Have you ever had injuries to your teeth, face or jaw? Yes No If yes, please explain: Manual Electr Have you ever had injuries to your teeth, face or jaw? Yes No If yes, please explain: Manual Electr Have you ever had injuries to your teeth, face or jaw? Yes No If yes, please explain: Manual Electr Have you ever had injuries to your teeth, face or jaw? Yes No If yes, please explain: Manual Electr Have you ever had injuries to your teeth, face or jaw? Yes No If yes, please explain: Manual Electr Have you ever had injuries to your teeth, face or jaw? Yes No If yes, please explain: Manual Electr Have you ever had injuries to your teeth, face or jaw? Yes No If yes, please explain: Manual Electr Have you ever had injuries to your teeth, face or jaw? Yes No If yes, please			c Metal Latex	Local Anesthetics Othe	er:
When were your last dental x-rays taken? How often do you brush? Times daily How often do you floss? Times daily Type of toothbrush: Manual Electre. Have you ever had braces/orthodontic treatment? Yes No If yes, please explain: Have you ever been treated for periodontal disease? Yes No If yes, when? Have you ever had injuries to your teeth, face or jaw? Yes No If yes, please explain: Do you experience, or have you experienced in the past, any of the following: Bad Breath Bleeding Gums Blisters on Mouth Broken Fillings/Teeth Clicking Jaw Dental Anxiety Difficulty Opening/Closing Difficulty Chewing Dry Mouth	AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Asthma Blood Disease Blood Transfusion Bleeding Problem Bruise Easily Cancer Chemotherapy Have you ever had a seri	Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Cortisone Medicine Diabetes Drug Addiction Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea	Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pace Maker Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure Hives or Rash Hypoglycemia	Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Parathyroid Disease Psychiatric Care Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism	Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disea Stroke Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice
How often do you brush? Times daily How often do you floss? Times daily Type of toothbrush: Manual Electr Have you ever had braces/orthodontic treatment? Yes No					
Bad Breath Bleeding Gums Blisters on Mouth Broken Fillings/Teeth Clicking Jaw Dentures Dental Anxiety Difficulty Opening/Closing Difficulty Chewing Dry Mouth	How often do you brush? Have you ever had brace Have you ever been trea	Times daily How oft ss/orthodontic treatment? Yested for periodontal disease?	en do you floss? Ti s No If yes, please explai Yes No If yes, when? _	mes daily Type of toothbrush:	Manual Electric
Ear Pain Jaw Pain Loose Teeth Missing Teeth Mouth Sores Sensitivity – Cold Sensitivity – Hot Sensitivity – Sweets Sensitivity – Pressure Swollen Gums What brings you into the office today? Do you have any questions or concerns about your smile or oral health?	Bad Breath Dentures Ear Pain Sensitivity – Cold	Bleeding Gums Dental Anxiety Jaw Pain Sensitivity – Hot	Blisters on Mouth Difficulty Opening/Closing Loose Teeth Sensitivity – Sweets	Difficulty Chewing Missing Teeth Sensitivity – Pressure	Dry Mouth Mouth Sores

Signature of Patient or Parent/Guardian: