New Patient Medical History

1st Family Dental
www.1fd.org

Patient Name: _____ Date of Birth: _____ Gender: _____ Age: _____

Although Dental personnel primarily treat the area in and around your mouth, your dental health can affect your overall health in many ways. Health problems you may have, or medications you may be taking, could have an important interrelationship with the dental treatment you may receive. Thank you for answering the following questions completely and accurately.

General Medical History

Are you under a physician's care now? ___Yes ___No If Yes, Please Explain: _____
Have you been hospitalized or had a major operation? ___Yes ___No If Yes, Please Explain: _____
Have you ever had a serious head/neck injury? ___Yes ___No If Yes, Please Explain: _____
Are you taking any medications/pills/drugs? ___Yes ___No If Yes, Please List: _____
Have you been hospitalized or had a major operation? ___Yes ___No If Yes, Please Explain: _____
Have you taken, or do you take, Phen-Fen or Redux? ___Yes ___No _____
Are you on a special diet? ___Yes ___No _____
Do you use tobacco products? ___Yes ___No For How Long, # packs/day: _____
Do you use controlled substances? ___Yes ___No _____
For Women: Are you: ___Pregnant/Trying to get pregnant? ___Nursing? ___Taking contraceptives? _____

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
☐ Anaphylaxis	☐ 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 Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ 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	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Bleeding Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had a serious illness not listed above? If Yes, please explain: _____

General Health History Comments:

Dental History

When was your last dental exam? _____ 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 _____ Electric
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
☐ Dentures	☐ Dental Anxiety	☐ Difficulty Opening/Closing	☐ Difficulty Chewing	☐ Dry Mouth
☐ 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?

To the best of my knowledge, the questions on this form have been answered completely and accurately. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform 1st Family Dental of any changes in medical status.

Signature of Patient or Parent/Guardian: _____ Date: _____