Trinity Dental Arts

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MEDICAL HISTORY

Patient Name _____ Birth Date _____

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.

Are you under a physician's care now?	○ Yes	○ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	○ Yes	○ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	If yes, please explain: _____
Are you on a special diet?	○ Yes	○ No	If yes, please explain: _____
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	

Women: Are you:

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

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

☐ Other If yes, please explain: _____

Please list all medications you are currently taking along with the dosage:

Do you have, or have you had, any of the following? (Check all that apply)

☐ Aids/Hiv Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Headaches
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

DENTAL HISTORY

Date of Last Dental Cleaning _____ Reason for this visit: _____

Have you ever had any complications following dental treatment? ◯ Yes ◯ No

If yes, please explain: _____

Do your gums bleed? ◯ Yes ◯ No

Are you concerned about your breath? ◯ Yes ◯ No

Do you have any sores or lumps in or near your mouth? ◯ Yes ◯ No If yes, where _____

Do you have or have you ever had any of the following? (Check all that apply)

☐ Soreness when chewing
☐ Difficulty in opening or closing your mouth
☐ Clenching or grinding your teeth
☐ Gag easily
☐ Frequent headaches
☐ Pain in jaw joints
☐ Periodontal treatment

Do you prefer to save your teeth? ◯ Yes ◯ No

How often do you brush? _____ Floss? _____

Are you interested in aesthetic dental work to improve your smile? ◯ Yes ◯ No

Are you interested and/or considering dental implants? ◯ Yes ◯ No

Do you wear a denture? ◯ Yes ◯ No

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 _____ **Date** _____