Hill Family Dentistry--Medical and Dental History

Patient Name:_____D.O.B._____

Medical History

Please check if you have or have had any of the following:

___AIDS/HIV
___Alzheimer's/Dementia
___Anaphylaxis
___Anemia
___Anxiety/Depression
___Asthma
___Blood disease
___Cancer
___Chemotherapy
___Chest pain
___Congenital heart disorder
___Diabetes
___Emphysema
___Epilepsy/Seizures
___Fainting/Dizziness
___Headaches/Migraines
___Heart attack
___Heart disease
___Heart pacemaker
___Hepatitis A
___Hepatitis B
___Hepatitis C
___High blood pressure
___High cholesterol
___Hives
___Hypoglycemia
___Irregular heartbeat
___Kidney disease
___Liver disease
___Low blood pressure
___Lung disease
___Osteoporosis
___Pain in jaw
___Psychiatric care
___Radiation treatment of the head or neck
___Renal dialysis
___Shingles
___Sinus trouble
___Sleep apnea
___Stomach disease
___Stroke
___Tonsillitis
___Tuberculosis
___Ulcers

Other medical conditions not listed _____
For women: Are you pregnant? _____ If so, how far along?_____

Medications

Please list ALL medications including over the counter (if you have a list, we will make a copy for you)

_____ _____
_____
_____

Allergies

Please check if you are allergic to any of the following:

_____Latex _____Penicillin _____Aspirin _____Dental Anesthetics _____Codeine
_____Ibuprofen _____Iodine _____Sulfa _____Other allergies_____

Other medical questions

Have you had a joint replacement? _____ If so, when? _____
Do you have an artificial heart valve?_____
Do you require antibiotic premed before dental treatment? _____

Do you take any blood thinners? _____ If so, please list _____

Have you ever taken medications or injections for osteoporosis (bisphosphonates) _____
If so, please list _____

Have you ever had head or neck radiation? _____

Have you had any recent hospitalizations or surgeries? _____If so, please describe_____
_____

Please see other side ---->

Emergency Contact

Name_____Phone_____Relationship_____

Medical Doctor_____ Phone_____

Dental History

Reason for today's visit _____Are you in pain? _____

Are you having any of the following: _____ broken/chipped teeth _____ grinding teeth _____ bleeding gums

_____sensitivity _____ jaw discomfort _____dental surgery, if so, please describe _____

Any unusual reactions to dental anesthesia? If so, please describe_____

Tobacco Use? Y/N _____If so, what kind and how often? _____

For New Patients:

Date of last dental x-rays_____Last dental cleaning and exam_____

Previous dentist_____ How did you hear about our office?_____