Metcalf Dental

COMPLETE HEALTH MEDICAL & DENTAL HISTORY FORM

Although in dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and serves as the gateway to many organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Therefore, it is very important that you answer all of these pertinent questions. Thank you. And remember, healthy smiles . . . better lives!

PATIENT INFORMATION

Today's Date:_____

Name:_____ Date of Birth & Current Age:_____

Name of Primary Care Physician:_____ Physician's Phone:_____

Name of Former Dentist:_____ Dentist's Phone:_____

Date of Last Dental Exam:_____ Date of Last Physical Exam:_____

Do you medicate prior to dental appointments? ❑ Yes ❑ No Why?_____

Reason for Today's Visit:_____

ALLERGIES: Are you allergic to any of the following?

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

❑ Other_____

ORAL HEALTH INFORMATION

Is there a specific dental problem that you currently have?_____

How many times a day do you brush your teeth?_____ Type of brush used: ❑ Electric ❑ Manual

Do you floss regularly? ❑ Yes ❑ No How often do you floss?_____ How often do you see a dentist?_____

Does your oral health concern you? ❑ Yes ❑ No If yes, why?_____

	Yes	No		Yes	No
Gums bleed while brushing or flossing?	❑	❑	Frequent headaches?	❑	❑
Teeth sensitive to hot/cold liquids/foods?	❑	❑	Clench or grind your teeth?	❑	❑
Teeth sensitive to sweet/sour liquids/foods?	❑	❑	Bite your lips or cheeks frequently?	❑	❑
Pain upon chewing hard foods?	❑	❑	Suffer from dry mouth?	❑	❑
Feel pain to any of your teeth?	❑	❑	Ever had any difficult extractions?	❑	❑
Sores or lumps in or near your mouth?	❑	❑	Prolonged bleeding following extractions?	❑	❑
Any head, neck or jaw injuries?	❑	❑	Ever had any orthodontic treatment?	❑	❑
Ever experienced any of these jaw problems?	❑	❑	Do you wear dentures or partials?	❑	❑
❑ Clicking ❑ Pain (joint, ear, side of face)			If yes, date placed:_____		
❑ Difficulty opening/closing ❑ Difficulty chewing			Does food tend to catch in between your teeth?	❑	❑
Interested in straighter teeth?	❑	❑	Interested in whiter teeth?	❑	❑
Do you like your smile?	❑	❑			

HEALTH INFORMATION: Do you currently have or ever had any of the following conditions?

Cardiovascular	Yes	No	***Skeletal***	Yes	No
High Blood Pressure	❑	❑	Arthritis	❑	❑
Heart Attack	❑	❑	Joint Replacement	❑	❑
Low Blood Pressure	❑	❑	Osteoporosis/Thin Bones	❑	❑
Heart Disease	❑	❑	***Respiratory***		
Cardiac Pacemaker	❑	❑	Asthma	❑	❑
Heart Murmur	❑	❑	Emphysema	❑	❑

Angina ❑ ❑
Chest Pain ❑ ❑
Easily Winded ❑ ❑
Stroke ❑ ❑
Heart Trouble ❑ ❑
Mitral Valve Prolapse ❑ ❑
Mini-Stroke (TIA) ❑ ❑
Swollen Ankles ❑ ❑
Heart Arrhythmia ❑ ❑
Atrial Fibrillation ❑ ❑
Brain/Aortic Aneurysm ❑ ❑
Poor Blood Flow to Extremities ❑ ❑

Blood

Bleeding/Clotting Problems ❑ ❑
Anemia ❑ ❑
High Cholesterol ❑ ❑
Blood Transfusions ❑ ❑

Mental Health

Depression ❑ ❑
Migraine Headaches ❑ ❑
Anxiety/Panic Attacks ❑ ❑
Sleep Disorder ❑ ❑
Mental Disability ❑ ❑
Fainting/Seizures ❑ ❑
Frequently tired ❑ ❑
Epilepsy/Convulsions ❑ ❑
Schizophrenia ❑ ❑
Bipolar Disorder ❑ ❑

Other

Psoriasis ❑ ❑
HIV/AIDS Infection ❑ ❑
Recent Weight Loss ❑ ❑
Tuberculosis ❑ ❑
Hay Fever/Allergies ❑ ❑
Chronic Obstructive Pulmonary Disease ❑ ❑
Respiratory Problems ❑ ❑

Endocrine

Diabetes ❑ ❑
Pre-Diabetes ❑ ❑
Liver Disease ❑ ❑
Thyroid Problems ❑ ❑
Stomach Problems/Ulcers ❑ ❑
Hepatitis/Jaundice ❑ ❑

Digestive

Chronic Heartburn ❑ ❑
Acid Reflux ❑ ❑

Autoimmune Conditions

Rheumatoid Arthritis ❑ ❑
Sjögren's Syndrome ❑ ❑
Lupus ❑ ❑
Autoimmune Disease ❑ ❑

Cancer ❑ ❑

If yes, which type? _____

❑ Radiation ❑ Chemotherapy ❑ Both

Females Only

Pregnant/Trying to Get Pregnant ❑ ❑
Nursing ❑ ❑

Other (cont.)

Sexually Transmitted Disease ❑ ❑
Kidney Disease ❑ ❑
Glaucoma ❑ ❑
Rheumatic Fever ❑ ❑
Physical Disability ❑ ❑
Eating Disorder ❑ ❑

Please list any conditions not already covered: _____

FAMILY HEALTH HISTORY INFORMATION: Please indicate any knowledge of family members (mother, father, grandmother, grandfather, sibling) that have had any of the following conditions:

	Yes	No		Yes	No
Heart Disease	❑	❑	Osteoporosis	❑	❑
Stroke	❑	❑	Peripheral Vascular Disease	❑	❑
Diabetes	❑	❑	Alzheimer's/Senility	❑	❑
Cancer	❑	❑	Autoimmune Disorders	❑	❑
Gum Disease	❑	❑			

MEDICATIONS

Please list all your prescription and non-prescription medications, vitamins, home remedies and herbs.

Medications/Supplements	*Dose (mg per pill, doses per day)*	*Start Date*	*End Date*

SOCIAL HISTORY INFORMATION

Do you smoke or use:	Never	Quit	Date You Quit	Currently Using	Times/Packs per Day
Cigarettes	❑	❑	_____	❑ for ____ years	_____
Chewing Tobacco	❑	❑	_____	❑ for ____ years	_____
E-Cigarettes	❑	❑	_____	❑ for ____ years	_____

Drink alcohol? ❑ Yes ❑ No How many drinks weekly?_____ Use controlled substances? ❑ Yes ❑ No

ANYTHING ELSE WE SHOULD KNOW

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 (the 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