Dental Patient Medical History Form

Personal Information

Full Name

Date of Birth

Phone Number

Email

Address

Medical Information

Are you currently under a physicianâ€™s care?

- Yes
- No

If yes, please explain:

Are you taking any medications?

- Yes
- No

If yes, please list them:

Do you have any allergies (including latex, medications, etc.)?

- Yes
- No

If yes, please specify:

Have you ever had any of the following? (Check all that apply)

- [ ] Heart Disease
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Cancer
- [ ] Asthma
- [ ] Epilepsy
- [ ] Bleeding Disorders
- [ ] Arthritis
- [ ] HIV/AIDS
- [ ] Other

If other, please specify:

Have you had any surgeries or hospitalizations?

- ○ Yes
- ○ No

If yes, please list and give dates:

Do you use tobacco products?

- ○ Yes
- ○ No

Do you drink alcohol?

- ○ Yes
- ○ No

For Women

Are you pregnant or nursing?

- ○ Yes
- ○ No

If pregnant, how many weeks?

Additional Information

Is there anything else about your health we should know?