

MEDICAL & HEALTH HISTORY



Dental personnel primarily treat the area in and around the mouth however; your mouth is a gateway to the entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will receive. Thank you for answering the following questions regarding your medical & health history.

Patient Name:	Date of Birth:	Age:	Home Phone:	Cell Phone:
Email:	Home Address:		City & Province	Postal Code:
Occupation:			Employer:	
Marital Status:	Emergency Contact: (Name)	Relationship:	Phone Number:	

Approximate date of last dental visit:	Reason for that visit:
What is your PRIMARY concern that you would like us to address today?	

Medical History Questions

1. Have you visited a physician for a medical condition? In the past two years? Yes No

If yes, please explain: _____

Physician: _____ Phone: _____

Medical Specialist: _____ Phone: _____

2. When was your last visit to a Physician? _____

Last complete Physical Examination? _____

3. Are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Or have you recently taken any?
Yes No

If yes, please list:

	Dosage: mL or mg	Frequency:
1.		
2.		
3.		
4.		
5.		

4. Have you been hospitalized in the past two years? Yes No

5. Have you ever reacted adversely to and of the following?

Antibiotics – Penicillin	Y <input type="radio"/>	N <input type="radio"/>	Codeine	Y <input type="radio"/>	N <input type="radio"/>
Sulfonamide	Y <input type="radio"/>	N <input type="radio"/>	Darvon	Y <input type="radio"/>	N <input type="radio"/>
Other Antibiotics	Y <input type="radio"/>	N <input type="radio"/>	Local Anesthetic (Freezing)	Y <input type="radio"/>	N <input type="radio"/>
Aspirin	Y <input type="radio"/>	N <input type="radio"/>	Nitrous Oxide	Y <input type="radio"/>	N <input type="radio"/>
Barbiturates (Sleeping Pills)	Y <input type="radio"/>	N <input type="radio"/>	Any Other Medications:		

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6. Have you ever been advised against taking any specific type of medication? Yes No

If yes, which medication(s): _____

7. Do you have any of the following?

Asthma	Y <input type="radio"/>	N <input type="radio"/>	Hay Fever	Y <input type="radio"/>	N <input type="radio"/>
Food Allergies	Y <input type="radio"/>	N <input type="radio"/>	Metal or Latex Allergies	Y <input type="radio"/>	N <input type="radio"/>
Skin Rashes	Y <input type="radio"/>	N <input type="radio"/>	Hives	Y <input type="radio"/>	N <input type="radio"/>
Any Other Allergic Condition	Y <input type="radio"/>	N <input type="radio"/>	Other:		

8. Has a family member had diabetes?	Y <input type="radio"/>	N <input type="radio"/>
9. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?	Y <input type="radio"/>	N <input type="radio"/>
10. Do your ankles or feet swell?	Y <input type="radio"/>	N <input type="radio"/>
11. Has your weight, appetite or energy level changed dramatically lately?	Y <input type="radio"/>	N <input type="radio"/>
12. Do you experience shortness of breath or chest pain when talking a walk or climbing stairs?	Y <input type="radio"/>	N <input type="radio"/>
13. Do you follow a specific diet?	Y <input type="radio"/>	N <input type="radio"/>
14. Have you recently tested HIV positive?	Y <input type="radio"/>	N <input type="radio"/>
15. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections?	Y <input type="radio"/>	N <input type="radio"/>
16. Have you ever had any injury or surgery to your face or jaw?	Y <input type="radio"/>	N <input type="radio"/>
17. Do you wear eyeglasses or contact lenses?	Y <input type="radio"/>	N <input type="radio"/>
18. Do you have any hearing difficulties?	Y <input type="radio"/>	N <input type="radio"/>
19. Do you smoke or use any other forms of tobacco?	Y <input type="radio"/>	N <input type="radio"/>
a. Are you wearing a transdermal nicotine patch?	Y <input type="radio"/>	N <input type="radio"/>
20. Are you alcohol and/ or drug dependant?	Y <input type="radio"/>	N <input type="radio"/>
a. Have you received any treatment?	Y <input type="radio"/>	N <input type="radio"/>

8. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD

A.I.D.S	Y <input type="radio"/>	N <input type="radio"/>	Anemia	Y <input type="radio"/>	N <input type="radio"/>	Angina Pectoris	Y <input type="radio"/>	N <input type="radio"/>
Arthritis/ Rheumatism	Y <input type="radio"/>	N <input type="radio"/>	Artificial Heart Valve	Y <input type="radio"/>	N <input type="radio"/>	Artificial Joints	Y <input type="radio"/>	N <input type="radio"/>
Blood Disorders	Y <input type="radio"/>	N <input type="radio"/>	Bronchitis	Y <input type="radio"/>	N <input type="radio"/>	Cancer	Y <input type="radio"/>	N <input type="radio"/>
Circulation Problems	Y <input type="radio"/>	N <input type="radio"/>	Congenital Heart Lesions	Y <input type="radio"/>	N <input type="radio"/>	Cortisone/ Steroid	Y <input type="radio"/>	N <input type="radio"/>
Diabetes	Y <input type="radio"/>	N <input type="radio"/>	Emphysema	Y <input type="radio"/>	N <input type="radio"/>	Epilepsy or Seizures	Y <input type="radio"/>	N <input type="radio"/>
Fainting or Dizzy Spells	Y <input type="radio"/>	N <input type="radio"/>	Glandular Disorders	Y <input type="radio"/>	N <input type="radio"/>	Glaucoma	Y <input type="radio"/>	N <input type="radio"/>
Head/ Neck Injuries	Y <input type="radio"/>	N <input type="radio"/>	Heart Disease or Attacks	Y <input type="radio"/>	N <input type="radio"/>	Heart Murmur	Y <input type="radio"/>	N <input type="radio"/>
Heart Pacemaker	Y <input type="radio"/>	N <input type="radio"/>	Heart Rhythm Disorder	Y <input type="radio"/>	N <input type="radio"/>	Heart Surgery	Y <input type="radio"/>	N <input type="radio"/>
Hepatitis A	Y <input type="radio"/>	N <input type="radio"/>	Hepatitis B	Y <input type="radio"/>	N <input type="radio"/>	Hepatitis C	Y <input type="radio"/>	N <input type="radio"/>
Herpes	Y <input type="radio"/>	N <input type="radio"/>	High/ Low Blood Pressure	Y <input type="radio"/>	N <input type="radio"/>	Hodgkin's Disease	Y <input type="radio"/>	N <input type="radio"/>
Hyper (Hypo) Glycemia	Y <input type="radio"/>	N <input type="radio"/>	Hypertension	Y <input type="radio"/>	N <input type="radio"/>	Jaundice	Y <input type="radio"/>	N <input type="radio"/>
Kidney Disease	Y <input type="radio"/>	N <input type="radio"/>	Liver Disease	Y <input type="radio"/>	N <input type="radio"/>	Lung Disease	Y <input type="radio"/>	N <input type="radio"/>
Malignant Hyperthermia	Y <input type="radio"/>	N <input type="radio"/>	Mental/ Nervous Disorder	Y <input type="radio"/>	N <input type="radio"/>	Mitral Valve Prolapse	Y <input type="radio"/>	N <input type="radio"/>
Organ Transplant	Y <input type="radio"/>	N <input type="radio"/>	Psychiatric Treatment	Y <input type="radio"/>	N <input type="radio"/>	Radiation/ Chemotherapy	Y <input type="radio"/>	N <input type="radio"/>
Rheumatic/ Scarlet Fever	Y <input type="radio"/>	N <input type="radio"/>	Sickle Cell Disease	Y <input type="radio"/>	N <input type="radio"/>	Sinus Trouble	Y <input type="radio"/>	N <input type="radio"/>
Stomach/ Intestinal Problems	Y <input type="radio"/>	N <input type="radio"/>	Stroke	Y <input type="radio"/>	N <input type="radio"/>	Thyroid Disease	Y <input type="radio"/>	N <input type="radio"/>
Tuberculosis	Y <input type="radio"/>	N <input type="radio"/>	Ulcers	Y <input type="radio"/>	N <input type="radio"/>	Venereal Disease	Y <input type="radio"/>	N <input type="radio"/>
Other:	In Office Blood Pressure Reading:							

9. Has the CHILD PATIENT recently had any of the following (indicate approximate date):

Measles	Y <input type="radio"/>	N <input type="radio"/>	Mumps	Y <input type="radio"/>	N <input type="radio"/>
Chicken Pox	Y <input type="radio"/>	N <input type="radio"/>	Strep Throat	Y <input type="radio"/>	N <input type="radio"/>
Tonsillitis	Y <input type="radio"/>	N <input type="radio"/>			

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10. (FOR WOMEN ONLY)

- Are you pregnant or suspect you might be? Yes No
 If yes, what is the expected birthdate? Yes No
 Are you taking birth control pills? Yes No

11. Do you currently have, or have you had in the past, any disease, condition, or problem not listed above?

Yes No _____

12. Is there anything else about your health we should be made aware of?

Yes No _____

13. Do you wish to speak to the Doctor privately about any problem or medical condition? Yes No

14. Thank you for completing your Medical Health History for our records. Just one last Question – Please tell us how you found Grover Dental Care: *Please circle (or check) the most appropriate source:*

Google/ Internet Search	Website (grovedentalcare.com)	Flyer in Mail	Word-of-mouth
Social Media (Facebook, Instagram)	Print Media (Newspaper, Magazine)	Community Events	Location/ Convenience of Office
Specialist Office	Existing Patient (From another office)	Friend or Family Member (Name):	
Other (Please write in any other source):			

Patient/ Guardian Signature: _____ **Date:** _____

Reviewed by Treating Dentist: _____ **Date:** _____