Lake Area Free Clinic

Dental Patient Medical History

General Medical Information			
Patient Name:		Date of birth:	
Name of Primary Care Physician:		Date of last exam:	
List names and locations of any medical specialist you see:			
List any serious injuries, surgeries, or other medical conditions:			
Has your physician or dentist ever recommended antibiotics before dental care? If so, what for?			
Please list any medications, OTC medications, or supplements you may take:			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Do you use tobacco? If so, list type and how often?			
Are you interested in quitting tobacco use? If yes, can we offer resources?			
Do you use recreational drugs or controlled substances? Be sure to notify your provider if used in the last 24 hours.			
Do you drink alcohol? If so how many per week?			

Do you have any of the following? If yes, please circle:		
AIDS/HIV	Hemophilia	Radiation Treatment
Alzheimer's Disease	Diabetes	Hepatitis A
Recent Weight Loss	Anaphylaxis	Drug/Alcohol Addiction
Hepatitis B or C	Renal Dialysis	Anemia
Rheumatic Fever	Emphysema/COPD	High Blood Pressure
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol
Artificial Heart Valve	Excessive Bleeding	Hives or Rash
Shingles	Artificial Joint	Excessive Thirst
Hypoglycemia	Sickle Cell Disease	Asthma
Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Frequent Cough	Kidney Problems	Leukemia
Stomach/Intestinal Disease	Frequent Headaches	Liver Disease
Stroke	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease
Thyroid Disease	Chemotherapy	Seasonal Allergies
Mitral Valve Prolapse	Chest Pains/Angina	Osteoporosis

Tuberculosis	Heart Murmur	Tumors or Growths
Congenital Heart Disease	Parathyroid Disease	Ulcers
Mental Health Disorders	Sexually Transmitted Disease	Acid Reflex/GERD
Autoimmune Disease	Cardiovascular Disease	Congestive Heart Failure
Eating Disorders	Heart Attack	Pacemaker
Pneumonia	Sleep Apnea	Bleeding Disorder
Hearing Impairment	Infective Endocarditis	Visual Impairment
Any serious illness not listed above? If yes, please list:		

Women: Are you…..		
Pregnant?	Nursing?	Taking oral contraceptives?

Do you have Allergies? If yes, please circle:			
Aspirin	Penicillin	Codeine	Acrylic
Latex	Sulfa Drugs	Local Anesthetics	Metal
Other Allergies? If yes, please list:			

Dental History
How long since last dental visit?
Reason for seeking dental treatment?
Do you wear partial or dentures?
Do you have frequent cold sores, blisters, or other oral lesions? If so, please explain?

Do you have any of the following? If yes, please circle:		
Cold Sensitivity	Hot Sensitivity	Sensitivity When Chewing
Sensitivity to Sweets	Difficulty Chewing	Sore Jaw
Clenching/Grinding	Popping/Clicking of Jaw	Difficulty Opening/Closing
Nervous at Dentist	Bleeding Gums	Food Caught in Teeth
Do you have any dental concerns not listed?		
Do you brush your teeth? If so, how often?		
Do you clean between your teeth? If so, what do you use and how often?		
So you consume sweetened beverages, such as soda, juice, coffee, or sports drinks? If so, how often and type?		
Do you snack between meals? If so, what and how often?		

To the best of my knowledge, the questions on the 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.

Patient Signature: _____ Date: _____