Time 10:51 AM | Dentistry By Design | Date 1/31/2017

Medical History Interview

Patient Name: | Birth Date: | Date Created:

A. Chief Complaint:

Are you in pain? ○ Yes ○ No If yes

Is there anything you would like changed about your smile? ○ Yes ○ No If yes

B. Dental History

When was your last Dental visit and what was it for? (emergency, general check-up, cleaning, etc...)

Date of most recent dental X-rays:

Any difficulties or complications with past dental treatment? ○ Yes ○ No If yes

Do you have pain in or around your jaw joints? ○ Yes ○ No If yes

Do you have clicking, popping, or grating noises in your jaw joints? ○ Yes ○ No If yes

Has your jaw ever locked open/closed? ○ Yes ○ No If yes

C. Medical History

Are you now or have you been under the care of a physician during the past 12 months? ○ Yes ○ No If yes

Physician's Name

Phone Number

When was your last visit and what was it for?

Do you take any medications at the present time? ○ Yes ○ No

Are you allergic to any of the following?

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

Other? ☐ If yes

Females Only:

Are you pregnant? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Do you take oral contraceptives? ○ Yes ○ No

Have you noted a change in your menstrua ○ Yes ○ No

D. Family History

Have any of your family members ever been treated for the conditions listed or any other medical problems?

☐ Diabetes	☐ High Blood Pressure	☐ Heart Problems	☐ Seizures

Other: ○ Yes ○ No If yes

E. Review of Systems

Have you ever had or do you now have any of the conditions listed?

Lack or loss of body hair	Yes No	Swollen, painful joints	Yes No
Prosthetic joints	Yes No	Blurring of vision	Yes No
Earache	Yes No	Frequent sore throat	Yes No
Cough, blood in sputum	Yes No	Tuberculosis	Yes No
Shortness of breath	Yes No	Pain, pressure in chest	Yes No
Swelling of ankles	Yes No	High blood pressure	Yes No
Low blood pressure	Yes No	Heart murmur, attack	Yes No
Prosthetic valves/pacemakers	Yes No	Abdominal pain, ulcers	Yes No
Hepatitis, jaundice	Yes No	Liver disease	Yes No
Herpes	Yes No	Thyroid trouble	Yes No
Weight change	Yes No	Diabetes	Yes No
Excessive thirst	Yes No	Easy brusing, excessive bleeding	Yes No
Anemia	Yes No	HIV infection, AIDS	Yes No
Leukemia	Yes No	Difficulty swallowing	Yes No
Frequent headaches	Yes No	Dizziness, fainting	Yes No
Epilepsy, seizures	Yes No	Parathesias, numbness	Yes No
Paralysis	Yes No	Depression, excessive worry	Yes No
Radiotherapy/chemotherapy	Yes No	Cancer	Yes No
Alzheimer's disease	Yes No	Congenital heart disorder	Yes No
Drug Addiction	Yes No	High cholesterol	Yes No
Kidney disease	Yes No	Osteoporosis	Yes No
History of bisphosphonate therapy	Yes No	Stroke	Yes No
History of migraines	Yes No	Asthma	Yes No

Any other medical condition not listed above?	Yes No	If yes
Do you suffer from dry mouth or lack of saliva?	Yes No	If yes
Have you ever had radiation to your head/neck	Yes No	If yes
Have you ever had chemotherapy for cancer	Yes No	If yes
Do you suffer from heartburn?	Yes No	If yes
Have you been diagnosed with GERD?	Yes No	If yes
Have you ever been diagnosed with an Autoimmune disorder?	Yes No	If yes

Signature of Patient, Parent or Guardian:

X

Date:_____