For office use only: Medical Alert☐

Trinity Family Dental Medical History

First Name: _____ Last Name: _____ Date of Birth: _____

In case of emergency contact: _____ Phone: _____

	Yes	No	Not sure/maybe
1. Are you being treated for any medical condition at the present or have been treated within the past year? If so, why? _____	☐	☐	☐
2. When was your last medical checkup? _____			
3. Has there been any change in your general health in the past year? If yes, please explain. _____	☐	☐	☐
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list (incl. names & dosages). _____ _____ _____	☐	☐	☐
5. Do you have any allergies? If yes, please list using the categories below: a) medication b) latex/rubber products c) other e.g. hayfever, foods _____	☐	☐	☐
6. Have you ever had a peculiar or adverse reaction to any medicines or injection? If yes, please explain. _____	☐	☐	☐
7. Do you have or have you ever had asthma?	☐	☐	☐
8. Do you have or have you ever had any heart or blood pressure problems?	☐	☐	☐
9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?	☐	☐	☐
10. Do you have a prosthetic or artificial joint?	☐	☐	☐
11. Have you ever been advised by your doctor/dentist to take antibiotics before dental treatment?	☐	☐	☐
12. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, and chemotherapy?	☐	☐	☐
13. Have you ever had hepatitis, jaundice or liver disease?	☐	☐	☐
14. Do you have a bleeding problem or bleeding disorder?	☐	☐	☐
15. Have you ever been hospitalized for any illness or operations? If yes, please explain. _____	☐	☐	☐

16. Do you have or have you ever had any of the following? Please check.

☐chest pain, angina	☐shortness of breath	☐cancer	☐steroid therapy	☐seizures(epilepsy)
☐heart attack	☐prosthetic heart valve	☐lung disease	☐diabetes	☐kidney disease
☐stroke	☐pacemaker	☐tuberculosis	☐stomach ulcers	☐thyroid disease
	☐drug/alcohol dependency	☐arthritis	☐diet pill therapy	

17. Are there any conditions or diseases not listed above that you have or have had? If yes, please list. _____	☐	☐	☐
18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) _____	☐	☐	☐

19. Do you smoke or chew tobacco products? ☐ ☐ ☐
20. Are you nervous during dental treatment? ☐ ☐ ☐
21. For women only: Are you breast-feeding or pregnant? ☐ ☐ ☐
    If pregnant, what is the expected delivery date?
    _____

22. Blood Pressure Reading(office use) _____

Dental History

1. When was your last dental visit? _____
2. When did you last have dental x-rays? _____
3. How often do you brush your teeth? _____
4. How often do your floss your teeth? _____

	Yes	No	Not sure/maybe
5. Have you been seeing a dentist regularly?	☐	☐	☐
6. Do any of your teeth ache?	☐	☐	☐
7. Do your gums bleed when you brush?	☐	☐	☐
8. Do you have any pain when you chew?	☐	☐	☐
9. Do you feel that you have bad breath?	☐	☐	☐
10. Are there any growths or sore spots in your mouth?	☐	☐	☐
11. Have you ever been in a vehicle accident or experienced any blows to your jaw?	☐	☐	☐
12. Have you ever had any implant surgery in one or both of your jaws or jaw joints? If yes, please provide: who performed the surgery _____, when _____	☐	☐	☐
13. Are you being followed-up by dental specialists? If yes, please provide names of the specialists_____	☐	☐	☐

14. Please list anything else not mentioned above regarding your past dental history.
    _____

15. What do you look for most in a dentist/dental office? _____

    _____

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for my dental care. I understand that responsibility for payment for the dental services for myself or my dependents is mine, and I will assume responsibility for fees associated with these services. Should there be any changes in either my health or personal information, I will advise the dentist and patient coordinator.

Patient/parent/guardian signature: _____ Date:_____

Dentist signature: _____ Date:_____