

**FIRST  
AVENUE  
FAMILY  
DENTISTRY**

**MEDICAL HISTORY FOR:**

MO	DAY	YR
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The following information is required by the dentist to assist in proper diagnosis and treatment. ALL INFORMATION IS CONFIDENTIAL.

		Yes	Don't Know Maybe	No
1.	Have you ever had a serious illness requiring hospitalization or extensive medical care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you presently under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you had a medical examination in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you use any prescription or non-prescription medications regularly? Specify: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have any allergic condition, i.e. asthma, hay fever, skin rash, food allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea? Specify: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you been hospitalized in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever experienced any unusual reaction to any of the following: <input type="checkbox"/> Local anaesthesia (freezing) <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Iodine <input type="checkbox"/> Sulfonamide <input type="checkbox"/> Barbiturates (sleeping pills)			
9.	Have you ever been warned against taking any drug or medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you have, or have you ever had, any of the following: <input type="checkbox"/> Heart murmur or mitral valve prolapse <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> AIDS <input type="checkbox"/> Hepatitis A/B/C <input type="checkbox"/> Liver disease <input type="checkbox"/> Stomach/intestinal problems <input type="checkbox"/> Drug/alcohol addiction <input type="checkbox"/> Positive testing for HIV virus <input type="checkbox"/> Herpes <input type="checkbox"/> Cortisone/steroid therapy <input type="checkbox"/> Joint replacement (hip, knee, etc.) <input type="checkbox"/> Venereal disease <input type="checkbox"/> Jaundice <input type="checkbox"/> Heart attack <input type="checkbox"/> Other <input type="checkbox"/> Mental or nervous disorder <input type="checkbox"/> Any lung disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cold sores <input type="checkbox"/> <input type="checkbox"/> High/low blood pressure <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Hyper/hypo glycemia <input type="checkbox"/> Arthritis or rheumatism <input type="checkbox"/> Kidney disease <input type="checkbox"/> <input type="checkbox"/> Epilepsy or seizures <input type="checkbox"/> Scarlet or rheumatic fever <input type="checkbox"/> Stroke <input type="checkbox"/> Sinus trouble <input type="text"/>			
11.	Have you ever had any known contact with the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Has any member of your family had diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Do you bruise easily or bleed abnormally?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Do your ankles swell during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you had any weight changes recently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Do you have any blood disorders such as anemia (thin blood), thalasseamia (major, minor)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Have you ever had radiation treatment or chemotherapy? If so, explain: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you ever had any injury, surgery or x-ray therapy to your face or jaws?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Do you have frequent severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Do you have frequent earaches, ear/throat infections, or any hearing difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	Is your eyesight: <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Are you on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Have you ever fainted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Do you ever experience shortness of breath or chest pain when walking or climbing stairs? If so, explain: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	Have you ever had any organ transplants or medical implants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	Do you have any disease, condition or problem that you think the doctor should know about? If so, explain: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	Is there anything about yourself that we should be made aware of? If so, explain: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	WOMEN ONLY – Are you pregnant? If so, what month are you in? <input type="text"/> – Are you taking any birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FIRST AVENUE

**DENTAL HISTORY FOR:**

[Empty box for patient name]

MO	DAY	YR
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		Yes	Don't Know Maybe	No
1.	Reason for today's visit: <input type="checkbox"/> Exam <input type="checkbox"/> Cleaning <input type="checkbox"/> Emergency <input type="checkbox"/> Other [ ] Is there a dental problem you would like to have taken care of as soon as possible? Specify: [ ]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	How frequently do you see your dentist? <input type="checkbox"/> 6 months <input type="checkbox"/> Yearly <input type="checkbox"/> Other [ ] Former dentist: [ ] Last dental visit: [ ] Last cleaning: [ ] Last full mouth x-rays: [ ] X-rays requested: [ ]			
3.	Have you been given oral hygiene instruction in: <input type="checkbox"/> Brushing <input type="checkbox"/> Flossing <input type="checkbox"/> Other [ ] By whom? [ ]			
4.	Brushing: <input type="checkbox"/> Vigorous <input type="checkbox"/> Light How often? [ ]			
5.	How often do you floss your teeth? [ ]			
6.	Other cleaning aids used: <input type="checkbox"/> Floss <input type="checkbox"/> Stimudents <input type="checkbox"/> Toothpaste <input type="checkbox"/> Other [ ]			
7.	Are any of your teeth sensitive to: <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/> Heat <input type="checkbox"/> Other [ ]			
8.	Do your gums bleed when: <input type="checkbox"/> Brushing <input type="checkbox"/> Flossing <input type="checkbox"/> Spontaneously			
9.	Is your sugar intake: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low			
10.	Have you ever had, or do you have, any of the following (please check) <input type="checkbox"/> Bridges <input type="checkbox"/> Lost fillings <input type="checkbox"/> Bite appliance/night guard <input type="checkbox"/> Gum treatments <input type="checkbox"/> Partial dentures <input type="checkbox"/> Extractions <input type="checkbox"/> Swelling or pain in your mouth or jaw <input type="checkbox"/> Gag easily <input type="checkbox"/> Full dentures <input type="checkbox"/> Loose teeth <input type="checkbox"/> Injuries to your face or jaws <input type="checkbox"/> Difficulty opening or closing your jaw <input type="checkbox"/> Root canal fillings <input type="checkbox"/> Orthodontic treatment <input type="checkbox"/> Surgery to your mouth <input type="checkbox"/> Dental implants <input type="checkbox"/> Bite adjustments			
11.	Do you chew on only one side of your mouth? If so, where? [ ]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does any part of your mouth hurt when clenched?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Does your jaw crack or pop when opened widely?			
14.	Do you have any pain in your ears?			
15.	Have you experienced any growth or sore spots in your mouth? If so, where? [ ]			
16.	Do you: <ul style="list-style-type: none"> <li><input type="checkbox"/> grind or clench your teeth during the day or night?</li> <li><input type="checkbox"/> mouth breathe while awake or asleep?</li> <li><input type="checkbox"/> bite your lips or cheeks regularly?</li> <li><input type="checkbox"/> hold any foreign objects with your teeth (pipe, pencils, nails)?</li> <li><input type="checkbox"/> smoke? <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Other [ ]</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
17.	Check any of the following you are interested in or you have thought about: <input type="checkbox"/> Orthodontics (braces) <input type="checkbox"/> Repairing chipped teeth <input type="checkbox"/> Improved gum health <input type="checkbox"/> Bonding (straightening) <input type="checkbox"/> Bleaching (whitening teeth) <input type="checkbox"/> Improving your bite <input type="checkbox"/> Closing spaces between teeth <input type="checkbox"/> Crowns (caps) <input type="checkbox"/> Improving breath odour <input type="checkbox"/> Replacing missing teeth <input type="checkbox"/> Sports mouth guard <input type="checkbox"/> Improving your smile			
18.	Would you rate your current health as: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
19.	Do you have any emotional concerns regarding your dental visit? <input type="checkbox"/> Fear <input type="checkbox"/> Pain <input type="checkbox"/> Time <input type="checkbox"/> Money <input type="checkbox"/> Embarrassment <input type="checkbox"/> Other [ ]			

Comments:

[Empty box for comments]

**INFORMED CONSENT/GENERAL RELEASE**

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding the Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as may be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services provided to me or my dependents.

Patient ( parent,  guardian) signature: \_\_\_\_\_

If parent, guardian\*, please print name: \_\_\_\_\_

Date (mm/dd/yyyy): \_\_\_\_\_

\*Guardian of child or guardian of adult under guardianship