Frank Family Dentistry
Medical History Form

Patient Name_____ **Street Address**_____
City_____
Date of Birth _____ **Best Phone # to Contact**_____
Today's Date _____ **Insurance**_____ **Policy #**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important relationship with the dental care you will receive. Thank you in advance for answering the following questions.

Please list your family physician and any medical specialists you see at least once a year:

NAME SPECIALTY PHONE NUMBER

_____

_____

_____

YES NO Do you consider yourself to be in good health?
YES NO Have you ever needed premedication with antibiotics prior to dental care?

Please list any history of hospitalization or surgery and the date: _____

_____

Do you **currently have** or have you **ever had**:

YES NO Allergic reactions to: Latex Penicillin Codeine Local Anesthetics Metals Other: _____
Reaction: _____
YES NO Heart Bypass, Stent or Artificial Heart Valve Type:_____ Date_____
YES NO Rheumatic fever or rheumatic heart disease
YES NO Heart Attack Date:_____
YES NO Stroke Date_____
YES NO Irregular Heartbeat or Pacemaker
YES NO High Blood Pressure
YES NO Congestive Heart Failure
YES NO Bacterial endocarditis
YES NO Thyroid disease
YES NO Anorexia or Bulimia
YES NO GERD or acid reflux
YES NO Kidney Disease
YES NO Artificial Joint(s) Joint: _____ Date: _____
YES NO Other artificial implants or devices
YES NO Bleeding problem, clotting disorder, anemia or other blood disease
YES NO Diabetes Type I or Type II Most recent HbA1c: _____
YES NO Seizures or any other nervous system disease
YES NO Hepatitis A, B, C or D or other liver disease
YES NO Asthma, tuberculosis, shortness of breath or other lung disease
YES NO Cancer Type_____
Chemotherapy (dates) _____ Radiation (dates) _____
YES NO Immunosuppressive condition (circle those that apply)
Prednisone therapy Cancer therapy Spleen removed Rheumatoid Arthritis
HIV/AIDS Organ Transplant SLE (Lupus) Other: _____
YES NO Are you being treated with or have you undergone osteoporosis therapy? Boniva pills Actonel Fosamax
YES NO Impairment of hearing or sight or speech
YES NO Physical or mental condition that may require special care
YES NO Are you or could you be pregnant? Are you nursing _____
YES NO Do you have any disease, condition, or problem not listed here?
Please describe: _____
YES NO Do you currently use or have you ever used recreational drugs in the past?
History of recreational drug use:_____
YES NO Do you currently smoke or use smokeless tobacco? Packs/day: _____
How interested are you in stopping your tobacco use? Very Somewhat Not at all

Methods used previously to assist in quitting: _____

YES NO Do you regularly take herbal medicines or dietary supplements?

Garlic Ginger St. John's Wort Valerian Feverfew
Ginkgo Kava Echinacea Kava Other: _____

Dental History

Why are you seeking dental care?_____

How often do you typically have dental exams and cleanings: _____

Date of last exam: _____

What type of toothbrush do you use: _____

How often do you brush your teeth: _____ How often do you floss: _____

YES NO Do you want to keep your teeth for your lifetime?

YES NO Are you happy with the appearance of your smile?

YES NO Have you had any trouble associated with previous dental treatment?

If so, please explain: _____

YES NO Has fear ever prevented you from seeking dental treatment?

YES NO Have you ever injured your face or jaw?

YES NO Have you noticed any lumps or sores in your mouth?

YES NO Do you get **cold sores** or **canker sores**? How many times a year?_____

YES NO Have you ever been advised about periodontal disease, or been treated for periodontal disease?

YES NO Do your gums bleed at any time?

YES NO Have you ever worn a night guard or mouth splint?

YES NO Are you allergic to any metals or dental materials?

YES NO Have you ever had TMJ pain or worn a nightguard or mouth splint?

Please circle the types of dental treatment or procedures you have had:

Orthodontics Root Canal Treatment Tissue Graft Implant Oral Surgery
Fillings TMJ treatment Periodontal (gum) surgery Dentures Crowns

If you could wave a magic wand and change one thing about your smile, what would it be: _____
_____

Please complete the following medication list, and then sign below:

Dr. Frank and Dr. Rinaldi request this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside of this office will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and keep you safe during dental treatment. By signing below, you agree that the information given is accurate and that you will notify us of any changes at subsequent appointments.

Patient signature: _____ Date:_____

Or patient representative: _____ Relationship to patient:_____

Please list all medicines and supplements that you are currently taking.

Date	Medicine or Supplement	Dose	Medical Condition	Date Discontinued	Notes