# Absolute Denture Clinic

## Dental Medical History Form

### 1. Patient Information

| | | | | |
|---|---|---|---|---|
| **Date of Birth:** | Month: | Day: | Year: | **SSN:** |
| **Legal Name:** | **First:** | | **MI:** | **Last:** |
| | Preferred Name: | | | |

### 2. Important Information For Your Dentist

1. List any allergies: _____
2. List any prescribed medications you are currently taking: _____
3. List any over-the-counter medications/vitamins you are taking: _____
4. List any previous reactions to local anesthetic, metals, or sedation: _____
5. List any illnesses/surgeries/hospitalizations: _____
6. Is pre-medication required before dental visits? ☐ Yes ☐ No
7. List any use of recreational drugs: _____

### 3. Primary Care Information

| | | |
|---|---|---|
| Physician: | Telephone Number: | Clinic/Facility: |

**All Patients:** Do you have, or have you ever had any of the following? (Check all that apply) ☐ NONE

| | | | |
|---|---|---|---|
| ☐ Abnormal Blood Pressure | ☐ Chemical Dependency | ☐ Heart Pacemaker | ☐ Prosthetic Implants |
| ☐ Alcohol Addiction | ☐ Chemotherapy | ☐ Hemophilia | ☐ Psychiatric Care |
| ☐ AIDS/HIV | ☐ Congenital Heart Disease | ☐ Hepatitis ☐A☐B☐C | ☐ Radiation Therapy |
| ☐ Anemia | ☐ Diabetes | ☐ Kidney Problems | ☐ Rheumatic Fever |
| ☐ Anorexia | ☐ Recreational Drugs | ☐ Learning Disability | ☐ Rheumatic Heart Disease |
| ☐ Artificial Heart Valve | ☐ Emphysema | ☐ Mitral Valve Prolapse | ☐ Sickle Cell Disease |
| ☐ Artificial Joint | ☐ Epilepsy/Seizures | ☐ Neurological Disorders | ☐ Sinus Trouble |
| ☐ Asthma/Breathing Issues | ☐ Fainting Spells | ☐ Organ Transplant | ☐ Stroke |
| ☐ Bulimia | ☐ Hearing Problems | ☐ Pregnant/Nursing | ☐ Tuberculosis |
| ☐ Cancer/Malignancy | ☐ Heart Disease/Surgery | ☐ Prolonged Bleeding | |

### 4. Dental History

| | |
|---|---|
| **Rate Your Oral Health:** | ☐ Excellent ☐ Good ☐ Fair ☐ Poor |
| **Date of Last Dental Visit:** _____ | **Treatment Type:** |

☐ Y / ☐ N Do you feel pain to any of your teeth? Hot/Cold/Sweet/Sour/Sensitivities. Pain when chewing?
☐ Y / ☐ N Do you have sores or lumps in or near your mouth?
☐ Y / ☐ N Have you had any head, neck or jaw injuries?
☐ Y / ☐ N Do you bite your lips or cheeks frequently?
☐ Y / ☐ N Have you ever experienced any of the following?
☐ Clicking in jaw ☐ Pain (joint, ear, side of face) ☐ Difficulty in opening or closing mouth ☐ Difficulty chewing
☐ Y / ☐ N Have you ever had prolonged bleeding following extractions?
☐ Y / ☐ N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc)
☐ Y / ☐ N Any unusual speech habits? If yes, explain: _____

| | | | |
|---|---|---|---|
| Any other dental concerns? | | | |
| Patient/Guardian Signature: | | Date: | |
| Dentist Signature: | | Date: | |