MEDICAL HISTORY QUESTIONNAIRE

art of smiles DENTISTRY

Patient Name

Last	First	MI	Birthdate

		No	Yes	If "Yes," please list question # and explain
1.	In any pain or discomfort?	☐	☐	
2.	Lost any teeth prematurely?	☐	☐	
3.	Ever had any injuries to the mouth?	☐	☐	
4.	Any unusual speech/breathing habits?	☐	☐	
5.	Any mouth habits (thumb sucking, etc.)?	☐	☐	
6.	Pregnant or nursing a baby?	☐	☐	
7.	Ever had any unhappy dental visits?	☐	☐	
8.	Using tobacco in any form?	☐	☐	
9.	Taking any medications/drugs?	☐	☐	
10.	Allergic to any substances?	☐	☐	

Date of last dental visit		Reason for last visit	
Previous dentist's name		Address	
Why did you not return to your previous dentist?			
Physician's name		Address	
List any physician's care within the last 3 years:			

	No	Yes				
Is your home water fluoridated?	☐	☐				
Do you drink soda (pop)?	☐	☐	How much?		How often?	
For ADULTS ONLY –						
How often do you brush?					How often do you floss?	
For MINORS ONLY –						
How often does your child brush?					How often does your child floss?	
Do you help your child brush?	☐	☐	If "Yes" →		How often do you help?	
Do you help your child floss?	☐	☐	If "Yes" →		How often do you help?	

PLEASE CHECK IF ANY OF THE FOLLOWING CONDITIONS ARE OR HAVE EVER BEEN APPLICABLE:

HEART
- ☐ Chest Pains
- ☐ Congenital Heart Lesion
- ☐ Hand/Feet/Ankle Swelling
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Artificial Heart Valve

JOINT
- ☐ Artificial Joints
- ☐ Arthritis/Gout
- ☐ Pain in Jaw Joints
- ☐ Rheumatic Fever
- ☐ Rheumatism

BLOOD
- ☐ AIDS (HIV)
- ☐ Anemia
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Cold Sores
- ☐ Fever Blisters
- ☐ Hemophilia
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B (serum)
- ☐ Herpes
- ☐ Prolonged Bleeding
- ☐ Sickle Cell Anemia

LUNGS
- ☐ Allergies/Hay Fever
- ☐ Asthma
- ☐ Emphysema
- ☐ Fainting/Dizzy Spells
- ☐ Frequent Coughing
- ☐ Lung Disease
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Rashes/Hives
- ☐ Tuberculosis

NERVE
- ☐ Alzheimer's Disease
- ☐ Anorexia/Bulimia
- ☐ Drug Addiction
- ☐ Nervousness
- ☐ Psychiatric Care
- ☐ Recent Weight Loss
- ☐ Strong Gag Reflex
- ☐ Taken Fen-Phen or Redux
- ☐ Ulcers

KIDNEY
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Hypoglycemia
- ☐ Kidney Trouble

- ☐ Alcoholism
- ☐ Cancer
- ☐ Chemo/Radiation Therapy
- ☐ X-ray/Cobalt Therapy
- ☐ Cortisone Medication
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Parathyroid Disease
- ☐ Thyroid Disease
- ☐ Venereal Disease

Please list all hospitalizations, surgeries or any other significant health problems not listed above:

Emergency Contact - - Name: | Tel. #

By signing below, I certify that this medical history accurately states all known conditions

Signature | Date

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