Hillside Family Dental Care

New Patient Medical History Form

Date: _____

WELCOME!

Although dental personnel primarily treat the area around your mouth, your mouth is part of your body. Health problems that you may have, or medications that you may take, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name: _____ **Preferred Name**: _____ **Date of Birth**: _____

Physician's Name: _____ **Location**: _____

Previous Dentist's Name: _____ Location: _____

When was the **last time you saw a dentist?** _____

How did you hear about our office? _____

Are you currently under a physician's care for an **ongoing health issue**? YES ☐ NO ☐ _____

Have you ever been **hospitalized or had a major operation**? YES ☐ NO ☐ _____

Have you ever had a serious **head, neck or jaw injury or surgery**? YES ☐ NO ☐ _____

Have you ever taken **bisphosphonates** (e.g. Fosamax, Zometa, Reclast)? YES ☐ NO ☐ _____

Are you **allergic** to anything? YES ☐ NO ☐ _____

Do you require **premedication prior to dental procedures**? YES ☐ NO ☐ _____

Are you taking any **medications**? YES ☐ NO ☐ _____

Do you use **controlled substances**? YES ☐ NO ☐ _____

Do you use **tobacco**? YES ☐ NO ☐ _____

Do you **vape**? YES ☐ NO ☐ _____

Do your gums **bleed**? YES ☐ NO ☐ _____

Are your teeth **sensitive**? YES ☐ NO ☐ _____

Do you have **pain** in your teeth? YES ☐ NO ☐ _____

Do you experience **frequent headaches**? YES ☐ NO ☐ _____

Do you have **clicking or pain in your jaw**? YES ☐ NO ☐ _____

Do you **clench or grind** your teeth? YES ☐ NO ☐ _____

Over →

Name: _____ **Date**: _____ **Date of Birth**: _____

Do you have, or have you had, any of the following **medical conditions**? Please answer **yes or no to all**.

ADD/ADHD	Y ☐ N ☐	Diabetes	Y ☐ N ☐	Kidney Problems/Dialysis	Y ☐ N ☐
AIDS/HIV Positive	Y ☐ N ☐	Drug Addiction	Y ☐ N ☐	Leukemia	Y ☐ N ☐
Alzheimer's Disease	Y ☐ N ☐	Emphysema	Y ☐ N ☐	Liver Disease	Y ☐ N ☐
Anemia	Y ☐ N ☐	Epilepsy	Y ☐ N ☐	Low Blood Pressure	Y ☐ N ☐
Angina	Y ☐ N ☐	Excessive Bleeding	Y ☐ N ☐	Lung Disease	Y ☐ N ☐
Anxiety	Y ☐ N ☐	Fainting Spells/Dizziness	Y ☐ N ☐	Lyme Disease	Y ☐ N ☐
Arthritis/Rheumatoid	Y ☐ N ☐	Fibromyalgia	Y ☐ N ☐	Mitral Valve Prolapse	Y ☐ N ☐
Artificial Heart Valve	Y ☐ N ☐	Glaucoma	Y ☐ N ☐	Parathyroid Disease	Y ☐ N ☐
Artificial Joint	Y ☐ N ☐	Gout	Y ☐ N ☐	Psychiatric Therapy	Y ☐ N ☐
Asthma	Y ☐ N ☐	Hearing Impaired	Y ☐ N ☐	Radiation Treatment	Y ☐ N ☐
Autism Spectrum	Y ☐ N ☐	Heart Attack/Failure	Y ☐ N ☐	Rheumatic Fever	Y ☐ N ☐
Blood Disease	Y ☐ N ☐	Heart Murmur	Y ☐ N ☐	Scarlet Fever	Y ☐ N ☐
Blood Transfusion	Y ☐ N ☐	Heart Pacemaker	Y ☐ N ☐	Shingles	Y ☐ N ☐
Cancer	Y ☐ N ☐	Heart Trouble/Disease	Y ☐ N ☐	Sickle Cell Disease	Y ☐ N ☐
Chemotherapy	Y ☐ N ☐	Hemophilia	Y ☐ N ☐	Sinus Trouble	Y ☐ N ☐
Chest Pain	Y ☐ N ☐	Hepatitis	Y ☐ N ☐	Stroke	Y ☐ N ☐
Cold Sores/Fever Blisters	Y ☐ N ☐	Herpes	Y ☐ N ☐	Thyroid Disease	Y ☐ N ☐
Congenital Heart Disorder	Y ☐ N ☐	High Blood Pressure	Y ☐ N ☐	Tuberculosis	Y ☐ N ☐
Convulsions	Y ☐ N ☐	Hives/Rash	Y ☐ N ☐	Tumors/Growths	Y ☐ N ☐
Cortisone Medicine	Y ☐ N ☐	Hypoglycemia	Y ☐ N ☐	Ulcers	Y ☐ N ☐
Dementia	Y ☐ N ☐	Intestinal Disease	Y ☐ N ☐		
Depression	Y ☐ N ☐	Irregular Heartbeat	Y ☐ N ☐		

If you have **any other serious illness not listed** or said **yes to any of the above**, please explain:

_____

FOR WOMEN ONLY:

Are you **pregnant**? YES ☐ NO ☐ _____

Trying to get pregnant? YES ☐ NO ☐ _____

Taking **oral contraceptives**? YES ☐ NO ☐ _____

Nursing? YES ☐ NO ☐ _____

AUTHORIZATION AND RELEASE:

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental staff of any changes in my medical status.

Signature of patient, parent or guardian: _____Date: _____

Reviewed by: _____ Date: _____