

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

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:** _____