MEDICAL DENTAL HISTORY FORM

Patient's Name_____ D. O. B._____ Age _____

CONTACT INFORMATION:

Name **Telephone**

Residential Staff: _____

Senior Administrator: _____

Legal Guardian: _____

Health Care Practitioner responsible for completing the form_____

Date:_____ Telephone: _____

Date of Most Recent Physical Exam:_____ Height:_____ Weight: _____

DOES THE PATIENT HAVE, OR HAS (S)HE EVER HAD ANY OF THE FOLLOWING?

	YES	NO	UNKNOWN	COMMENTS
Any breathing or respiratory problems?.....	[ ]	[ ]	[ ]	
Asthma? (If yes answer a,b).....	[ ]	[ ]	[ ]	
a)If yes, is patient steroid dependent?.....	[ ]	[ ]	[ ]	
b)Does patient use an inhaler?.....	[ ]	[ ]	[ ]	
Sinus Problems?.....	[ ]	[ ]	[ ]	
Seasonal allergies or hayfever?.....	[ ]	[ ]	[ ]	
Airway obstructions?.....	[ ]	[ ]	[ ]	
Difficulty with intubation during general anesthesia?.....	[ ]	[ ]	[ ]	
Any difficulty with general anesthesia?.....	[ ]	[ ]	[ ]	
A smoking habit?.....	[ ]	[ ]	[ ]	
Positive P. P. D. Results?.....	[ ]	[ ]	[ ]	
If positive, date of last chest x-ray.....	[ ]	[ ]	[ ]	
History of TB?.....	[ ]	[ ]	[ ]	
High blood pressure?.....	[ ]	[ ]	[ ]	
Low blood pressure?.....	[ ]	[ ]	[ ]	
Angina?.....	[ ]	[ ]	[ ]	
Heart Attack?.....	[ ]	[ ]	[ ]	
Stroke?.....	[ ]	[ ]	[ ]	
Coronary Artery disease?.....	[ ]	[ ]	[ ]	
Arrhythmias?.....	[ ]	[ ]	[ ]	
Rheumatic Fever.....	[ ]	[ ]	[ ]	
Heart murmur?.....	[ ]	[ ]	[ ]	
Inborn heart defects?.....	[ ]	[ ]	[ ]	
Mitral Valve prolapse?.....	[ ]	[ ]	[ ]	
Artificial Heart Valves?.....	[ ]	[ ]	[ ]	
Pacemaker? (If yes, answer a).....	[ ]	[ ]	[ ]	
a) Should electronic devices be avoided?	[ ]	[ ]	[ ]	
Heart Surgery?.....	[ ]	[ ]	[ ]	
Does patient require antibiotics before dental treatment	[ ]	[ ]	[ ]	
Blood dyscrasias?...	[ ]	[ ]	[ ]	
Sickle Cell anemia?.....	[ ]	[ ]	[ ]	
Thyroid problems?.....	[ ]	[ ]	[ ]	

MEDICAL DENTAL HISTORY FORM

	YES	NO	UNKNOWN	COMMENTS
Diabetes? (If yes answer a-c)…	[ ]	[ ]	[ ]	
a) If diabetic is patient on insulin?……	[ ]	[ ]	[ ]	
b) If diabetic is patient well controlled?……	[ ]	[ ]	[ ]	
c) If diabetic is patient on oral medications?……	[ ]	[ ]	[ ]	
Liver Disease?……	[ ]	[ ]	[ ]	
Hepatitis A ?……	[ ]	[ ]	[ ]	
Hepatitis B ?……	[ ]	[ ]	[ ]	
Hepatitis C ?……	[ ]	[ ]	[ ]	
Stomach or duodenal ulcer?……	[ ]	[ ]	[ ]	
GERD (Gastro Esophageal Reflux Disease)……	[ ]	[ ]	[ ]	
Colitis ?……	[ ]	[ ]	[ ]	
Kidney stones ?…	[ ]	[ ]	[ ]	
Glaucoma ?…	[ ]	[ ]	[ ]	
Cancer ? (If yes please answer a-d)…	[ ]	[ ]	[ ]	
a) What type of cancer did patient have?…	[ ]	[ ]	[ ]	
b) Chemotherapy?…(If yes list dates)…	[ ]	[ ]	[ ]	
c) Radiation ?…(If yes list dates)….	[ ]	[ ]	[ ]	
d) Other treatment for cancer ?…	[ ]	[ ]	[ ]	
Facial or Jaw trauma?……	[ ]	[ ]	[ ]	
Scoliosis?……	[ ]	[ ]	[ ]	
Bone, joint or muscular problems?……	[ ]	[ ]	[ ]	
Artificial joints or surgically placed prosthesis?……	[ ]	[ ]	[ ]	
Arthritis ?……	[ ]	[ ]	[ ]	
If yes, how long?……	[ ]	[ ]	[ ]	
Any problems with local anesthesia ?……	[ ]	[ ]	[ ]	
Fainting with local anesthesia?……	[ ]	[ ]	[ ]	
Allergy to local anesthesia ? If so, what happened?……	[ ]	[ ]	[ ]	
Difficulty getting numb ?……	[ ]	[ ]	[ ]	
History of paresthesia ?……	[ ]	[ ]	[ ]	

Communication Skills:

Speech	Verbal	[ ]	Non-Verbal	[ ]		
Hearing	Normal	[ ]	Impaired	[ ]	Deaf	[ ]
Vision	Normal	[ ]	Impaired	[ ]	Blind	[ ]

Neurological Disorders?……	[ ]	[ ]	[ ]	
Epilepsy?……	[ ]	[ ]	[ ]	
Mental or emotional problems ?……	[ ]	[ ]	[ ]	
Alcohol or substance abuse?……	[ ]	[ ]	[ ]	

Allergies

Allergy to latex ?……	[ ]	[ ]	[ ]	
Allergy to nickel, acrylic or other ?……	[ ]	[ ]	[ ]	
Allergic to any medications or foods? (If yes please list)……	[ ]	[ ]	[ ]	

MEDICAL DENTAL HISTORY FORM

Female Patients only:	YES	NO	UNKNOWN	COMMENTS
Pregnant?….....	[ ]	[ ]	[ ]	
Taking birth control pills?….....	[ ]	[ ]	[ ]	
HIV positive?	[ ]	[ ]	[ ]	
Has patient had any infections in the last 2 weeks?……	[ ]	[ ]	[ ]	

Does patient have any medical problems not mentioned above? (Please list).

Please list all prescription and non-prescription medications, and herbal products that the patient is presently taking:

Medication	**Dosage**	**Frequency**
Attach Additional Sheet if Necessary		

Have there been any medications the patient has had to stop because of side effects?

TO BE COMPLETED BY DENTIST:
Dental Implications Regarding Medication / Dental History:

Do any of the above medications effect the QT interval?

YES [ ] NO [ ]

YES [ ] NO [ ]

Dentist's Signature _____

Name (printed) _____ **Date** _____
For Use by DDS (notes)

Developed through the OPWDD New York State Dental Task Force on Special Dentistry.