Wood Family Dentistry

Client Medical History Form

We are a health centered dental practice. Thus, we are concerned with your total well-being, not just your oral health. An essential part of our approach is a thorough health history. Please fill out the health questionnaire below completely – even if some of the questions may not seem relevant to your dental health. Thank you!

What are your hobbies or special interests? (i.e.: sports, self-improvement, education) _____

Please check either Y (yes) or N (no) as applicable.

Do you have, or have you ever had any of the following:

Hypoglycemia, Diabetes	Yes No	Prosthetic Valves, Joints, or Implants	Yes No
Heart Attack or Heart Trouble	Yes No	Stroke	Yes No
Hay Fever, Asthma, Allergies	Yes No	Heart Murmur, Mitral Valve Prolapse	Yes No
High Blood Pressure	Yes No	Rheumatic Fever	Yes No
Circulatory Problems	Yes No	Anemia, Blood Disorder	Yes No
Hepatitis, Jaundice	Yes No	Excessive Bleeding	Yes No
Lung Problems, Tuberculosis	Yes No	Fainting, Blackouts	Yes No
Epilepsy, Seizures	Yes No	Nervous Disorders	Yes No
Blood Transfusion	Yes No	Headaches, Migraines	Yes No
Facial or Head Injuries	Yes No	Kidney Problems	Yes No
Radiation, Chemotherapy	Yes No	Glaucoma, Eye Problems	Yes No
Malignancies, Cancer	Yes No	Ulcers, Digestive Problems	Yes No
Sinus Problems	Yes No	History of Eating Disorders	Yes No
AIDS, ARC	Yes No	Are you pregnant now?	Yes No
HIV Positive	Yes No	Are you nursing or taking birth control pills?	Yes No
Arthritis or Rheumatism	Yes No	Venereal Diseases	Yes No

Name of physician _____ Phone _____ Date of last physical _____

Have you been hospitalized in the last two years? Yes No If yes, please explain. _____

Do you consume alcohol or use tobacco? Yes No In what quantities? _____

Have you had unfavorable reactions to any of the following? (Please check all that apply)

☐ Aspirin ☐ Latex ☐ Codeine ☐ Anesthetics ☐ Xylocaine ☐ Novocaine ☐ Sedatives ☐ Penicillin ☐ Erythromycin ☐ Other Antibiotics

Other Drugs _____

Please list any drugs currently being taken _____

Reason for this dental visit _____

Date of last dental visit _____ What was done at that time? _____

Have you ever been treated by a periodontist, orthodontist, or endodontist? Yes No If yes, please explain _____

_____ Date of last x-rays _____

Are you happy with the appearance of your teeth? Yes No

Pharmacy _____ Phone/Cross streets _____

Have you noticed any of the following?

Teeth tender to chew on	Yes No	Recurring sore in or around the mouth	Yes No
Discomfort in face, head, neck, jaw	Yes No	Jaw clicking or popping	Yes No
Food caught between teeth	Yes No	Loose teeth	Yes No
Bleeding or sore gums	Yes No	Swelling, lumps in mouth	Yes No
Sensitivity to sweets, hot or cold	Yes No	Do you need nitrous, oral or IV sedation for dental visits?	Yes No

Have you had any problems with previous dental treatment? Yes No

If so, please explain _____

The information above is correct to the best of my knowledge.

Signature _____ Date _____

Submit