Medical History Form

Premed Needed?
Reason:

Date: __________

Schutze Family Dentistry P.C.

Name: ______________________________ Name You Prefer to Be Called: __________
Birth Date: __________________ Ht: ________ Wt: ________ SS#: ______________
Address: ______________________________ Phone(H) __________ (W) ________
Employer: ______________________ Location: ______________________
Any Physical Limitations: Handicap... Eye Problems...Difficulty Hearing...Other: __________
Who to Contact in an Emergency: __________________ Relation: ________ Ph# ________

Do You Have or Ever Had Medical Conditions Involving the Following: (Please Circle Any that Apply)

Allergies (Please List Allergies)		
Food Allergies	Yes	No
Drug Allergies (List Existing Allergies Below)	Yes	No
________ ________ ________		
________ ________ ________		
Dental Anesthesia	Yes	No
Heart/ Blood Vessels		
AIDS/HIV	Yes	No
Angina/Chest pains	Yes	No
Artificial Valve	Yes	No
Endocarditis	Yes	No
Heart Murmur(Needs Premed? Yes No)	Yes	No
Blood Transfusion	Yes	No
Heart Attack/Heart Failure	Yes	No
Pace Maker/ Atrial Fibrillation	Yes	No
Heart Disease	Yes	No
High or Low Blood Pressure	Yes	No
Irregular Heart Beat	Yes	No
Mitral Valve Prolapse	Yes	No
Shortness of Breath	Yes	No
Heart Related Surgeries	Yes	No
Blood		
Blood Disease	Yes	No
Lyme Disease	Yes	No
Anemia	Yes	No
Taking Blood Thinners	Yes	No
Excessive Bleeding/Clotting	Yes	No
Hemophilia	Yes	No
Bruise Easily	Yes	No
Neurological		
Stroke	Yes	No
Frequent Headaches	Yes	No
Seizures/Convulsions	Yes	No
Fainting Spells/Dizziness/Vertigo	Yes	No
Muscles and Bones		
Arthritis	Yes	No
Gout	Yes	No
Artificial Joint (Needs Premed? Yes No)	Yes	No
Osteoporosis/Osteopenia	Yes	No
Taking Bisphosphonates (e.g. Fosamax, Actonel, Boniva)	Yes	No

Respiratory		
Asthma/Breathing Problems	Yes	No
COPD	Yes	No
Sinus Problems	Yes	No
Lung Disease	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Frequent Cough	Yes	No
Difficulty Breathing Lying Down	Yes	No
Sleep Apnea	Yes	No
Loud Snoring	Yes	No
Acid Reflux/Taking Antacids Regularly	Yes	No
Endocrine		
Diabetes	Yes	No
Thyroid /Goiter/Graves Condition	Yes	No
Low or High Blood Sugar	Yes	No
Intestinal/Urinary System		
Hepatitis	Yes	No
Jaundice	Yes	No
Ulcers	Yes	No
Frequent Diarrhea	Yes	No
Genital Herpes	Yes	No
Kidney Disease	Yes	No
Venereal Disease	Yes	No
Cancer		
History of Tumor or Growth	Yes	No
Chemotherapy	Yes	No
Radiation Therapy	Yes	No
Catscan/MRI/Ultrasound	Yes	No
Cancer related Surgeries	Yes	No
Taking any of the following		
Steroids Within the Past 2 Years	Yes	No
Vitamins...Herbs...Supplements	Yes	No
Non-Prescription Drugs on Reg. Basis	Yes	No
Women Only: Are You:		
Pregnant or Nursing	Yes	No
Trying to Become Pregnant	Yes	No
Taking Hormones	Yes	No
Taking Birth Control Pills	Yes	No
Prone to Yeast Infection with Antibiotics	Yes	No

Over

Other

Are You in Good Health? Yes No
Any Health Changes in the Last Year? Yes No
Recent Weight Gain or Loss? Yes No
Currently Under a Physician's Care? Yes No
Abuse of Drugs or Alcohol? Yes No
Depression/Psychiatric Care? Yes No
Tobacco Use...Amount (____________) Yes No
Interested in Quitting? Yes No
Ever Been Hospitalized? Yes No

Other Surgeries or Conditions We Should Be Aware of? ______________________________
____
____

Primary Care Dr.________________________
Phone #____________________________
Last Medical Exam______________________

Current Prescription Drugs (Do you have a list of medications? Yes No)

Name of Drug: Dose: Why:

____
____
____
____
____
____

Dental Health History

(Please Circle All that Apply)

Purpose of Visit? ______________________
Previous Dentist? ______________________
Last Dental Visit? ______________________
What Was Done? ______________________

Have You Had:

Anxiety About Dentistry? Yes No
Anxiety About Needles or Blood? Yes No
Difficulty Getting Numb? Yes No
Serious Dental Problems? Yes No
Explain:
Satisfactory Dental Care? Yes No
Explain:

Do You Have:

Pain? Where? Yes No
Bleeding When Brushing or Flossing? Yes No
Gums that Feel Tender or Swollen? Yes No
Lumps or Growths in Mouth or Neck? Yes No
Canker/Cold Sores? Yes No
Difficulty or Painful Swallowing? Yes No
Teeth Sensitive to Hot/Cold/Sweets? Yes No
Strong Gag Reflex? Yes No

Do You:

Chew Only on One Side? Yes No
Explain:
Avoid Brushing Areas of Your Mouth? Yes No
Explain:

Clench/Grind Your Teeth While Asleep? Yes No
Clench/Grind Teeth While Awake? Yes No
Eat Any of the Following Daily?
Lemons/Candy/Mints/Cough Drops Yes No
Sip Drinks Throughout the Day? Yes No
Drink Energy Drinks Frequently? Yes No
Actively Playing Musical Instruments? Yes No

Have You Had:

Jaws that Feel Tired? Yes No
TMJ Jaw Therapy or Treatment? Yes No
Accident or Injury to Head and Neck? Yes No
Explain:
Migraines or Facial Pain? Yes No
Teeth Shifting or Loosened? Yes No
Persistent Dry Mouth? Yes No
Anything Else We Should Know?

Ever Had the Following Treatments(Approx Dates)

Periodontal Surgery (Gums):
Oral Surgery (Extractions):
Orthodontics (Braces):
Endodontics (Root Canals):

Last Updated

Date	Initials	Date	Initials

Patient signature ______________________________