Medical History: Dental Patients

1. Please enter your information.

First Name: _____ Last Name: _____ Age _____ Gender: ○ Female ○ Male

Mobile Phone: _____ Email: _____ Height(feet) _____ Height(inches) _____ Weight(lbs) _____

Office Name _____ Name of the Doctor _____

2. Level of anxiousness about visiting the dentist:

1 = None / 5 = Uncomfortable / 10 = Hiding under the bed

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

If greater than 5, please share your feelings:

_____

3. Check if you have or have had any of the following: Cardiovascular

Problem	YES	NO
High Blood Pressure		
Irregular Heart Beat		
Heart Murmur/Valve Disease		
Heart Attack		
Coronary Stents		
Pacemaker and/or Defibrillator		
Bleeding Disorder		
Stroke		
Anemia		

4. Check if you have or have had any of the following: Pulmonary/Airway

PROBLEM	YES	NO
Sleep Apnea		
Asthma		
COPD/Emphysema		
Tracheostomy		
Smoking		
Vocal Cord Injury		
Difficult Airway		

5. Check if you have or have had any of the following: Neuro/Developmental

PROBLEM	YES	NO
Multiple Sclerosis		
Seizures/Epilepsy		
Parkinson's		
Alzheimer's/Dementia		
Cerebral Palsy		
Down Syndrome		
ADHD		
Autism		

6. Check if you have or have had any of the following: Other

PROBLEM	YES	NO
Thyroid Disease		
Kidney Disease		
Acid Reflux/GERD		
Slow Gastric Emptying		
Hepatitis and/or Liver Disease		
Cancer		
Arthritis		
Diabetes		

7. Anesthesia Specific Questions: Please mark if you have any of the following:

	YES	NO	Explain if necessary
TMJ			
Neck Mobility Problems			
Mobility Issues			
Nerve Damage			
Do you use an inhaler			
Do you use a CPAP			
Alcohol Use and amount:			
Recreational Drug use and type:			
Have you had any problems with anesthesia before			

8. List medications you are currently taking Type NONE if not applicable

	Medication		Medication
1		2	
3		4	

9. Please list any allergies you may have: Type NONE if not applicable

	Allergy		Allergy
1		2	

10. Women

Are you pregnant?
○ Yes ○ No

Are you nursing?
○ Yes ○ No

Are you taking birth control?
○ Yes ○ No