Palms Dentistry
Your home for health, wellness, life

Dental Medical History Form

1. Patient Information

Date of Birth:	Month:	Day:	Year:	**SSN:**
Legal Name:	**First:**		**MI:**	**Last:**
	Preferred Name:			

2. Important Information For Your Dentist

1. List any allergies: _____
2. List any prescribed medications you are currently taking: _____
3. List any over-the-counter medications/vitamins you are taking: _____
4. List any previous reactions to local anesthetic, metals, or sedation: _____
5. List any illnesses/surgeries/hospitalizations: _____
6. Is pre-medication required before dental visits? ☐ Yes ☐ No
7. List any use of recreational drugs: _____

3. Primary Care Information

Physician:	Telephone Number:	Clinic/Facility:

All Patients: Do you have, or have you ever had any of the following? (Check all that apply) ☐ NONE

☐ Abnormal Blood Pressure	☐ Chemical Dependency	☐ Heart Pacemaker	☐ Prosthetic Implants
☐ Alcohol Addiction	☐ Chemotherapy	☐ Hemophilia	☐ Psychiatric Care
☐ AIDS/HIV	☐ Congenital Heart Disease	☐ Hepatitis ☐A☐B☐C	☐ Radiation Therapy
☐ Anemia	☐ Diabetes	☐ Kidney Problems	☐ Rheumatic Fever
☐ Anorexia	☐ Recreational Drugs	☐ Learning Disability	☐ Rheumatic Heart Disease
☐ Artificial Heart Valve	☐ Emphysema	☐ Mitral Valve Prolapse	☐ Sickle Cell Disease
☐ Artificial Joint	☐ Epilepsy/Seizures	☐ Neurological Disorders	☐ Sinus Trouble
☐ Asthma/Breathing Issues	☐ Fainting Spells	☐ Organ Transplant	☐ Stroke
☐ Bulimia	☐ Hearing Problems	☐ Pregnant/Nursing	☐ Tuberculosis
☐Cancer/Malignancy	☐ Heart Disease/Surgery	☐ Prolonged Bleeding	

4. Dental History

Rate Your Oral Health:	☐ Excellent ☐ Good ☐ Fair ☐ Poor
Date of Last Dental Visit: _____	**Treatment Type:**

☐ **Y /** ☐ **N** Do you feel pain to any of your teeth? Hot/Cold/Sweet/Sour/Sensitivities. Pain when chewing?
☐ **Y /** ☐ **N** Do you have sores or lumps in or near your mouth?
☐ **Y /** ☐ **N** Have you had any head, neck or jaw injuries?
☐ **Y /** ☐ **N** Do you bite your lips or cheeks frequently?
☐ **Y /** ☐ **N** Have you ever experienced any of the following?
☐ Clicking in jaw ☐ Pain (joint, ear, side of face) ☐ Difficulty in opening or closing mouth ☐ Difficulty chewing
☐ **Y /** ☐ **N** Have you ever had prolonged bleeding following extractions?
☐ **Y /** ☐ **N** Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc)
☐ **Y /** ☐ **N** Any unusual speech habits? If yes, explain: _____

Any other dental concerns?			
Patient/Guardian Signature:		Date:	
Dentist Signature:		Date:	

Board Approved: January 19, 2017