FAMILY DENTISTRY
OF CENTRAL CONNECTICUT

Medical and Dental Health History Form
Getting to Know You As Our Patient

Patient name (first and last): _____ Date_____

Name of previous dentist/location: _____

Date of last dental examination: _____Date of Last Dental cleaning _____

Why have you come to see us today (e.g. pain, checkup, etc.)? _____

How did you hear about our practice (please circle) Insurance Directory Newspaper Internet Search Mailer

Google Drive/ Walk by Referred by friend/family/doctor other _____

Who can we thank for referring you to our practice _____

Dental Health:

Yes	No	
☐	☐	Do you brush your teeth? How often? _____
☐	☐	Do you floss? How often? _____
☐	☐	Are you having any pain or discomfort at this time?
☐	☐	Do your gums bleed while brushing and flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Have you ever experienced any of the following problems with your jaw?

(Circle all that apply): clicking pain difficulty in opening and closing difficulty in chewing locking jaw

☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth? If yes, when? _____
☐	☐	Have you ever had any orthodontic treatment? If so, do you wear a retainer? _____
☐	☐	Have you ever had facial surgery? If so, when and what area of your face? _____
☐	☐	Do you wear dentures or partials? If so, date of placement:_____
☐	☐	Are you pleased with the appearance of your teeth when you smile?
☐	☐	Is there any dental treatment you are not happy with?
☐	☐	Are you nervous about dental treatment?
☐	☐	Do you snore? Or have you been told you snore?

For Women Only

Are you pregnant? If yes, Due date _____ nursing? Y/ N OB provider name _____

Is there anything not listed that you think we need to know about you, your dental past or your health? Please state _____

_____

_____

Medical Health If you have any questions about this form or are unsure how to answer a question, we'd be happy to assist you, please ask!

Name of Physician _____ Phone # _____

Address _____Date of last visit _____

Yes	No	
☐	☐	Are in good health?
☐	☐	Are you under the care of a physician?
☐	☐	Have you been hospitalized during the past two years?
☐	☐	Have you been asked by your medical doctor to premedicate before any dental treatment?
☐	☐	Do you smoke or use chewing tobacco? How much? _____
☐	☐	Do you drink alcohol? If yes, how often and in what quantity?

Are you allergic or have you reacted adversely to any of the following (check circle all that apply):

Aspirin Ibuprofen Codeine Penicillin Nitrous Oxide Acetaminophen/Tylenol Latex Metals Plastic
Other _____

Check any of the following that you have had or have at the present:

_____ Osteoporosis
_____ Heart disease or heart attack
_____ Abnormal blood pressure
_____ Heart murmur/mitral valve prolapse
_____ Rheumatic fever
_____ Heart pacemaker
_____ Heart surgery, What Kind and When?_____
_____ Artificial Heart Valve
_____ Epilepsy or seizures
_____ Psychiatric treatment
_____ Kidney disease
_____ Anemia
_____ Arthritis
_____ Bleeding disorders
_____ Taking blood thinners
_____ Ulcers
_____ Acid Reflux
_____ Obstructive Sleep Apnea

___ Bisphosphonate therapy (e.g. Boniva)
___ Asthma /Allergies
___ Diabetes (HgA1c _____)
___ Thyroid issues
___ Hepatitis A, B, C
___ Coronary Artery Disease
___ Congenital (birth defect) heart lesions
___ Stroke
___ History of drug addiction /alchoholism
___ Artificial joints (knee/hip/other joints)
___ Previous orthopedic surgery
___ AIDS or HIV+
___ Tuberculosis or lung disease
___ Sinus issues
___ Liver disease
___ Herpes
Cancer/chemotherapy/radiation

Other: _____

Major surgeries (type and year): _____
_____
_____

Please list all medications you are currently taking, including prescription drugs and over-the-counter drugs.

_____
_____

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment.
If there is any change in my medical status I will inform the dentist.

Signature: _____ Date: _____