Long Island
Select Healthcare

MEDICAL HISTORY FOR DENTAL PATIENTS

Welcome! Please fill out this form accurately so that we may provide you with the best possible care.

Patient Name: _____ Date: _____

Allergies: _____ Date of Birth: _____

1) Please give the name and phone number of your **medical** doctor _____
_____
2) Date of last visit with medical doctor _____
3) Are you taking any medication, drugs or pills now? YES NO
If YES, please give name and dosage _____
_____
_____
4) Have you had an allergic or adverse reaction to any medication or substance? YES NO
If YES, please describe:_____
5) Have you been a patient in the hospital during the past 5 years? YES NO
If YES, please list_____
6) Which of the following have you had before or have at present. **Check all items that apply to you:**

☐Heart Surgery, Disease or Attack	☐Diet: Special or Restricted	☐Hepatitis A, B or C
☐Chest Pain / Angina	☐Ulcers / Stomach Problems	☐HIV Positive / AIDS
☐Heart Pacemaker	☐Diabetes	☐Bleeding Disorder
☐Heart Murmur	☐Thyroid Problems	☐Sickle Cell Anemia
☐Mitral Valve Prolapse	☐Respiratory / Lung Problems	☐Liver Disease
☐High Blood Pressure	☐Asthma	☐Lyme Disease
☐Artificial Joints / Valves	☐Sinus Trouble	☐Neurological Disorder
☐Rheumatic Fever	☐Radiation Therapy	☐Epilepsy or Seizures
☐Stroke	☐Chemotherapy	☐Kidney Trouble
☐Arthritis / Rheumatism	☐Psychiatric / Psychological Care	☐Other Explain

_____

Genetic Syndrome/ Developmental Disability Type: _____

7) Social History Alcohol / Drug use: YES NO
Smoking: YES NO How many years? _____
8) Behavioral Management Considerations: _____
_____

Women:	Are you pregnant?	YES	NO
	Taking Birth Control?	YES	NO
	Nursing?	YES	NO

9) What is the reason for your visit today? _____
_____
10) Do you have any dental problems now? YES NO
If YES, please describe: _____
_____
11) How long has it been since you saw a dentist and what treatment was done? _____
_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

*Medical History will be verified in eClinical Works