Dental Medical History Form Checklist

Health Services

AUDIT VERIFICATION

Patient/Guardian Name

Dentist Signature

SIGNATURE

GENERAL DETAILS

Patient's Name

Date of Birth

DATE

2017-01-01

Age

Sex

Contact phone numbers

Issue

Do you have any Dental pain?

Yes No

Last examination date if any

Was the previous dental care satisfying?

Yes No NA

Are you scared of dental treatment?

Yes No Not sure

Any other concern area.

OVERALL CHECKS

Do you have any allergies?

Yes No

Mention the name of the medicine/ treatment if any

Do you have any previous record/issues/reactions to local anesthetic, metals, or sedation

Mention any previous illnesses/surgeries/hospitalizations

Mention the name of recreational drugs if any

Please select the medical history(at present or previously followed)if any

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