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 year? YES NO
   If YES, please list_____

6) Are you currently taking any anticoagulants?

7) Please circle any specialists you see on a regular basis:

Pulmonary Cardiology Hematology Rheumatology Endocrinology Other_____

8) Have you had any diagnostic testing or lab work done in the past 6 months? If so, where?

_____

9) 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: _____

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

_____

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

12) What is the reason for your visit today? _____

_____

13) Do you have any dental problems now? YES NO

If YES, please describe: _____

_____

14) 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 medical/ and or dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the medical practitioner/ dentist of any changes in my health ormedication.

Patient/Guardian Signature _____ Date _____

If not the patient, please state the:

Relationship to Patient _____

Interpreter's Name (if an interpreter is present) _____

*Medical History will be verified in eClinical Works