MEDICAL DENTAL HISTORY FORM

Consumer's Name_____ D. O. B. _____ Age _____

CONTACT INFORMATION:

	Name	**Telephone**
Residential Staff:	_____	_____
Senior Administrator:	_____	_____
Legal Guardian:	_____	_____

Health Care Practitoner responsible for completing the form_____

Date: _____ Telephone: _____

Date of Most Recent Physical Exam: _____ Height: _____ Weight: _____

DOES THE CONSUMER HAVE, OR HAS (S)HE EVER HAD ANY OF THE FOLLOWING?

	YES	NO	UNKNOWN	COMMENTS
Any breathing or respiratory problems?…….……	[ ]	[ ]	[ ]	_____
Asthma? (If yes answer a,b)……	[ ]	[ ]	[ ]	_____
a) If yes, is consumer steroid dependent?……	[ ]	[ ]	[ ]	_____
b) Does consumer use an inhaler?……	[ ]	[ ]	[ ]	_____
Sinus Problems?……	[ ]	[ ]	[ ]	_____
Seasonal allergies or hayfever?……	[ ]	[ ]	[ ]	_____
Airway obstructions?……	[ ]	[ ]	[ ]	_____
Difficulty with intubation during general anesthesia?……	[ ]	[ ]	[ ]	_____
Any difficulty with general anesthesia?……	[ ]	[ ]	[ ]	_____
A smoking habit ?……	[ ]	[ ]	[ ]	_____
Positive P. P. D. Results?……	[ ]	[ ]	[ ]	_____
If positive, date of last chest x-ray……	[ ]	[ ]	[ ]	_____
History of TB?……	[ ]	[ ]	[ ]	_____
High blood pressure?……..……	[ ]	[ ]	[ ]	_____
Low blood pressure?…….....	[ ]	[ ]	[ ]	_____
Angina?……	[ ]	[ ]	[ ]	_____
Heart Attack?……	[ ]	[ ]	[ ]	_____
Stroke?……	[ ]	[ ]	[ ]	_____
Coronary Artery disease?……	[ ]	[ ]	[ ]	_____
Arrhythmias?……	[ ]	[ ]	[ ]	_____
Rheumatic Fever……	[ ]	[ ]	[ ]	_____
Heart murmur?……	[ ]	[ ]	[ ]	_____
Inborn heart defects?……	[ ]	[ ]	[ ]	_____
Mitral Valve prolapse?……	[ ]	[ ]	[ ]	_____
Artificial Heart Valves?……	[ ]	[ ]	[ ]	_____
Pacemaker? (If yes, answer a)……	[ ]	[ ]	[ ]	_____
a) Should electronic devices be avoided? ……	[ ]	[ ]	[ ]	_____
Heart Surgery?……	[ ]	[ ]	[ ]	_____
Does consumer require antibiotics before dental treatment?	[ ]	[ ]	[ ]	_____
Blood dyscrasias?……	[ ]	[ ]	[ ]	_____
Sickle Cell anemia?……	[ ]	[ ]	[ ]	_____
Thyroid problems?……	[ ]	[ ]	[ ]	_____

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	YES	NO	UNKNOWN	COMMENTS
Diabetes? (If yes answer a-c)……	[ ]	[ ]	[ ]	_____
a) If diabetic is consumer on insulin?……	[ ]	[ ]	[ ]	_____
b) If diabetic is consumer well controlled?……	[ ]	[ ]	[ ]	_____
c) If diabetic is consumer on oral medications?……	[ ]	[ ]	[ ]	_____
Liver Disease?……	[ ]	[ ]	[ ]	_____
Hepatitis A ?……	[ ]	[ ]	[ ]	_____
Hepatitis B ?……	[ ]	[ ]	[ ]	_____
Hepatitis C ?……	[ ]	[ ]	[ ]	_____
Stomach or duodenal ulcer?……	[ ]	[ ]	[ ]	_____
GERD (Gastro Esophageal Reflux Disease)……	[ ]	[ ]	[ ]	_____
Colitis ?……	[ ]	[ ]	[ ]	_____
Kidney stones ?……	[ ]	[ ]	[ ]	_____
Glaucoma ?……	[ ]	[ ]	[ ]	_____
Cancer ? (If yes please answer a-d)……	[ ]	[ ]	[ ]	_____
a) What type of cancer did consumer have?……	[ ]	[ ]	[ ]	_____
b) Chemotherapy ?…(If yes list dates)……	[ ]	[ ]	[ ]	_____
c) Radiation ?…(If yes list dates)……	[ ]	[ ]	[ ]	_____
d) Other treatment for cancer ?……	[ ]	[ ]	[ ]	_____
Facial or Jaw trauma?……	[ ]	[ ]	[ ]	_____
Scoliosis?……	[ ]	[ ]	[ ]	_____
Bone, joint or muscular problems?……	[ ]	[ ]	[ ]	_____
Artificial joints or surgically placed prosthesis?……	[ ]	[ ]	[ ]	_____
Arthritis ?……	[ ]	[ ]	[ ]	_____
If yes, how long?……	[ ]	[ ]	[ ]	_____
Any problems with local anesthesia ?……	[ ]	[ ]	[ ]	_____
Fainting with local anesthesia?……	[ ]	[ ]	[ ]	_____
Allergy to local anesthesia ? If so, what happened?……	[ ]	[ ]	[ ]	_____
Difficulty getting numb ?……	[ ]	[ ]	[ ]	_____
History of paresthesia ?……	[ ]	[ ]	[ ]	_____

Communication Skills:

Speech	Verbal [ ]	Non-Verbal [ ]	
Hearing	Normal [ ]	Impaired [ ]	Deaf [ ]
Vision	Normal [ ]	Impaired [ ]	Blind [ ]

Neurological Disorders?……	[ ]	[ ]	[ ]	_____
Epilepsy?……	[ ]	[ ]	[ ]	_____
Mental or emotional problems ?……	[ ]	[ ]	[ ]	_____
Alcohol or substance abuse?……	[ ]	[ ]	[ ]	_____

Allergies

Allergy to latex ?……	[ ]	[ ]	[ ]	_____
Allergy to nickel, acrylic or other ?……	[ ]	[ ]	[ ]	_____
Allergic to any medications or foods? (If yes please list)……	[ ]	[ ]	[ ]	_____

MEDICAL DENTAL HISTORY FORM

Female Patients only:	YES	NO	UNKNOWN	COMMENTS
Pregnant ?……	[ ]	[ ]	[ ]	_____
Taking birth control pills?……	[ ]	[ ]	[ ]	_____
HIV positive?	[ ]	[ ]	[ ]	_____
Has consumer had any infections in the last 2 weeks?…….	[ ]	[ ]	[ ]	_____

Does consumer have any medical problems not mentioned above? (Please list).

_____

_____

Please list all prescription and non-prescription medications, and herbal products that consumer is presently taking:

Medication	**Dosage**	**Frequency**

Attach Additional Sheet if Necessary

Have there been any medications the consumer has had to stop because of side effects?

_____ _____

_____ _____

_____ _____

TO BE COMPLETED BY DENTIST:
Dental Implications Regarding Medication / Dental History:

_____

_____

_____

_____

Do any of the above medications effect the QT interval?

_____ **YES [ ] NO [ ]**

_____ **YES [ ] NO [ ]**

Dentist's Signature _____

Name (printed) _____ **Date** _____

For Use by DDS (notes)

Developed through the OMRDD New York State Dental Task Force on Special Dentistry.