Family Dental Care
of Indiana, LLC

Medical History

Patient Name _____ Preferred Name: _____
Date of Birth _____ Phone: _____

Reason for today's office visit? _____

	Yes	No
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health in the past year?	☐	☐
3. Are you under the care of a physician? Date of last visit_____	☐	☐
If so, for what are you being treated? _____		
4. Have you had any illness, operation or been hospitalized in the past 5 years?	☐	☐
If so, describe _____		
5. Do you have a prosthetic joint/implant? If so, where_____	☐	☐
6. Have you had a heart valve replacement or vascular graft?	☐	☐
7. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐

Have you had, or do you have:	Yes	No
Rheumatic Fever		
Damaged Heart Valves/Prolapse		
Heart Murmur		
High Blood Pressure		
Low Blood Pressure		
Chest Pain/angina		
Heart Attack		
Irregular heart beat		
Cardiac Pacemaker		
Heart Surgery		
Pneumonia, Bronchitis, Chronic cough		
Asthma		
Hay fever/sinus problems		
Snoring/sleep apnea		
Difficult breathing/other lung trouble		
Tuberculosis		
Emphysema		
Do you smoke? # of packs daily_____		
Do you use chewing tobacco		
Blood transfusion		
Blood disorder (anemia)		
Bruise easily		
Abnormal bleeding		
Hepatitis, jaundice, liver disease		
Infectious mononucleosis		
Gallbladder trouble		
Fainting spells		
Convulsions/epilepsy		
Stroke		
Thyroid trouble		

Have you had, or do you have:	Yes	No
Diabetes		
Low blood suger		
Kidney trouble		
High cholesterol		
Are you on dialysis		
Arthritis/joint disease		
Osteoporosis/osteopenia		
Osteonecrosis		
Stomach ulcers/acid reflux		
Contagious diseases		
Problems with immune system		
Delay in healing		
Tumor of growth		
Cancer/radiation/chemotherapy		
Chronic fatigue		
Are you on a diet		
History of alcohol abuse		
History of drug abuse		
Eye disease/glaucoma		
Mental health problems/ anxiety/depression		
Dental History		
Pain or clicking of jaws when eating		
Gums bleed while brushing or flossing		
Teeth are sensitive to hot or cold		
Teeth with sensitivity to sweets		
Pain with teeth		
Sores or lumps in or near mouth		
Head, neck or jaw injury		
Clench or grind your teeth		
Frequent headaches		
Orthodontic treatment		

Women Only:	**Yes**	**No**
Is there a possibility that you are pregnant?	☐	☐
Expected delivery date? _____		

	Yes	**No**
Are you nursing?	☐	☐
Are you taking birth Control?	☐	☐

Antibiotics (such as penicillin)may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding other methods of birth control.