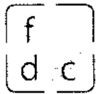

Family Dental Care
of Indiana, LLC

Medical History

Patient Name ______________________ Preferred Name: __________
Date of Birth ___________
Address ____
Phone Number ______________ Mobile Number ______________

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/ Seizures		
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		

(OVER)

Family Dental Care
of Indiana, LLC

Medical History

Are you currently taking:	Yes	No
Any medication, drug or pills		
Blood thinners (coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)		
Have you ever taken diet pills		
Any natural product, herbal supplement or homeopathic		
Are you taking or have you ever taken bone density medications or bisphosphonates (Fosamax, Boniva, Actonel, IV-Zometa or Aredia)		

Are you allergiec to or had a reaction to:	Yes	No
Local anesthetics (numbing medications)		
Penicillin		
Other antibiotics		
Sulfa Drugs		
Aspirin		
Amoxicillin		
Codeine		
Other medications		
Latex		
Do you have any known allergies		

Please list your current medications:

Medication	Dose	Frequency

Please list any other allergies:

Is there any health condition that the doctor should be aware of:

____

____

Do you wish to talk to the doctor privately? ☐Yes ☐No

Women Only:	**Yes**	**No**		**Yes**	**No**
Is there a possibility that you are pregnant?	☐	☐	Are you nursing?	☐	☐
Expected delivery date? ______________			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.

I certify that I understand the above information and to the best of my knowledge the above questions have been answered. I understand that providing incorrect information can be dangerous to my health. I will not hold my doctor, or any other member of her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient, Parent or Guardian Date Reviewed by Date

I authorize my dentist and her team to perform a dental exam for the purpose of diagnosis and treatment panning. I authorize the taking of all x-rays required as a necessary part of this examination. Additionally I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointments.

Signature of Patient, Parent/Guardian Date Witness Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient, Parent/Guardian Date