Medical History Form

RUCHI GROVER, D.D.S.
GENTLE DENTISTRY

Today's date ______________________

Patient name ______________________ Date of birth ____/____/____

Although we provide only dental assessment and care, we know there is a dental-whole body health connection. Medical problems or medications could have an important interrelationship with your dental treatment or situation. Thank you for taking the time to keep us fully informed about your medical history and status.

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local anesthetics (novocaine) ☐ Metal(s) if yes, what kind(s): ______________________

☐ Acrylic ☐ Latex ☐ Other, please explain: ______________________

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For women: Are you using contraceptive or hormone replacement drugs? ☐ Y ☐ N Are you breastfeeding ☐ Y ☐ N
Are you, or are you trying to become, pregnant? ☐ Y ☐ N

Have you had a serious illness or surgery or been hospitalized in the past 5 years? If so, please list or explain: ______________________

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Please list any medications or drugs you are currently taking: ______________________

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If you currently have a physician, what is her or his name, location, and phone number: ______________________

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Have you ever had a negative reaction to local anesthetic (novocaine)? ☐ Y ☐ N

Please indicate if you have, or have had, any of the following conditions (check all that apply):

☐ AIDS/HIV positive
☐ Acid reflux
☐ Adrenocortical insufficiency
☐ Alcoholism
☐ Anemia
☐ Angina
☐ Arthritis/gout
☐ Artificial heart valve
☐ Artificial Joint
☐ Asthma
☐ Blood disease
☐ Breathing problem
☐ Bruise easily
☐ COPD
☐ Cancer or tumor
☐ Chemotherapy
☐ Chest pains
☐ Cold sores/fever blisters
☐ Congenital heart disorder
☐ Diabetes
☐ Drug addiction
☐ Emphysema
☐ Epilepsy or seizures
☐ Excessive bleeding
☐ Excessive thirst
☐ Frequent cough
☐ Frequent headaches
☐ Glaucoma
☐ Heart attack/disease
☐ Heart pace maker
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ High blood pressure
☐ Hives or rash
☐ Hypoglycemia
☐ Jaundice
☐ Kidney problems
☐ Liver disease
☐ Low blood pressure
☐ Lung disease
☐ Lupus
☐ Parathyroid disease
☐ Parkinson's disease
☐ Psychiatric care
☐ Radiation treatments
☐ Renal dialysis
☐ Rheumatism
☐ Scarlet fever
☐ Sexually transmitted disease
☐ Shingles
☐ Sickle cell disease
☐ Sinus trouble
☐ Stomach/intestinal disease
☐ Stroke
☐ Swelling of limbs
☐ Thyroid problems
☐ Tobacco use
☐ Tuberculosis
☐ Ulcers

Have you ever had any serious illness or condition not listed above? ☐ Y ☐ N If yes, please explain: ______________________

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I understand the above information is necessary to provide me with care in a safe and efficient manner. To the best of my knowledge, the information I have provided is accurate. I agree to inform Gentle Dentistry of any changes in my medical status. I authorize Gentle Dentistry staff to consult with my physician(s) and any dental health professionals as needed for optimal health care coordination.

Signature ______________________ Date ______________________

Parent or legal guardian please sign if applicable. (Relationship to patient is: ______________________)

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