Dental Associates of Baraboo, SC
880 14th Street, Baraboo WI 53913
(608) 356.6611

MEDICAL HEALTH HISTORY

Today's Date: _____

Patient Last Name: _____ First Name: _____ MI: ___

Date of Birth: _____ Date of last **Medical** Exam: _____

Physician's Name: _____

Clinic Address/Location: _____ Physician's Phone #: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Emergency Contact name: _____ Contact Phone #: _____

Have you had any major health problems? (illness, surgery, hospitalization, etc.)

Yes ◯ No ◯

If **YES**, please give dates and explain:

Please list any prescription or NON-prescription **medications** you are currently taking (including herbal medication or recreational drugs):

Have you ever been told by a physician that you need to **pre-medicate** prior to dental treatment?

Yes ◯ No ◯

If **YES**, for what reason, how long ago, and what medication have you taken in the past?

_____

Do you or have you had any of the following conditions:
(Please check **YES** to any that apply)

Allergy - Ibuprofen	Yes ☐	Allergy - Ceclor	Yes ☐	Allergy - Erythromycin	Yes ☐
Allergy - Amoxicillin	Yes ☐	Allergy - Codeine	Yes ☐	Allergy - Latex	Yes ☐
Allergy - Anesthetic	Yes ☐	Allergy - Epinephrine	Yes ☐	Allergy - Morphine	Yes ☐
Allergy - Aspirin	Yes ☐			Allergy - Penicillin	Yes ☐

Allergy - Sedative Yes ☐
Allergy - Sulfa Yes ☐
Allergy - Tetracycline Yes ☐
Environmental Allergy Yes ☐
Allergy - Foods Yes ☐
Allergy - Other Yes ☐
If yes, what?
_____
Heart Murmur Yes ☐
Joint Replacement Yes ☐
If yes, when and where?
_____
Mitral Valve Prolapse Yes ☐
If yes, when?
_____
Pace Maker Yes ☐
If yes, when?
_____
Acid Reflux Disease Yes ☐
AIDS Yes ☐
Alzheimer's Disease Yes ☐
Anemia Yes ☐
Aneurysm Yes ☐
If yes, when?
_____
Anxiety Yes ☐
Arthritis Yes ☐
Artificial Heart Valve Yes ☐
Aspergers Syndrome Yes ☐
Asthma Yes ☐
Attention Deficit Yes ☐
Autism Yes ☐
Back Problems Yes ☐
Birth Control Pills Yes ☐
Bladder Over-Active Yes ☐
Bleeding Conditions Yes ☐
Blindness Yes ☐
Blood Disease Yes ☐
Blood Thinner Yes ☐
Blood Transfusions Yes ☐
Brain Condition Yes ☐

Breathing Problems Yes ☐
Bronchitis Yes ☐
Cancer Yes ☐
Type: _____
Cerebral Palsy Yes ☐
Circulation Problem Yes ☐
Chemotherapy Yes ☐
Crohns Disease Yes ☐
Convulsions Yes ☐
COPD Yes ☐
Cortisone-Steroid Tx Yes ☐
Dementia Yes ☐
Dental Phobic Yes ☐
Depression Yes ☐
Diabetes Yes ☐
Dizziness Yes ☐
Downs Syndrome Yes ☐
Drug/Alcohol Abuse Yes ☐
Eating Disorder Yes ☐
Emphysema Yes ☐
Epilepsy Yes ☐
Fainting Yes ☐
Fibromyalgia Yes ☐
Glaucoma Yes ☐
Gout Yes ☐
Head or Jaw Injury Yes ☐
Hearing Loss Yes ☐
Heart Attack Yes ☐
Heart Condition Yes ☐
Heart Surgery Yes ☐
Heart Trouble Yes ☐
Hepatitis/Liver Disease Yes ☐
Type: _____
Herpes Yes ☐
High Blood Pressure Yes ☐
High Cholesterol Yes ☐
HIV Yes ☐
Hormone Therapy Yes ☐
Immune Deficiency Yes ☐
Intestinal Problems Yes ☐
Kidney Condition Yes ☐

Laryngeal Problems Yes ☐
Low Blood Pressure Yes ☐
Lupus Yes ☐
Lyme Disease Yes ☐
Macular Degeneration Yes ☐
Migraine Headaches Yes ☐
Mononucleosis Yes ☐
MRSA Yes ☐
Multiple Sclerosis Yes ☐
Muscle Spasms Yes ☐
Nervous Disorder Yes ☐
Osteoporosis Yes ☐
Parkinsons Disease Yes ☐
Pregnant Yes ☐
If yes, when is your due date?_____
Radiation Treatment Yes ☐
Respiratory Disease Yes ☐
Rheumatic Fever Yes ☐
Scarlet Fever Yes ☐
Seizures Yes ☐
Sexually Trans. Disease Yes ☐
Sickle Cell Trait Yes ☐
Sinus Condition Yes ☐
Sleeping Problems Yes ☐
Snoring Problems Yes ☐
Special Needs Yes ☐
Stroke Yes ☐
Supplements Yes ☐
Tobacco Use?
Cigar Yes ☐
Cigarette Yes ☐
Chewing Yes ☐
Thyroid Hypo/Hyper Yes ☐
Tonsillitis Yes ☐
Tuberculosis Yes ☐
Tumors/Growths Yes ☐
Typhoid Fever Yes ☐
Ulcer Yes ☐
Venereal Disease Yes ☐

Please explain all **YES** answers:

DENTAL HEALTH HISTORY

Purpose of this visit?

Are you aware of any dental problems?

_____

How long since your last dental visit? _____

What was done at that time? _____

Your previous dentist's name: _____

How did you find out about our office? Internet ☐ Phone Book ☐ Friend/Co-worker ☐

Referred by: _____

When was the last time your teeth were cleaned? _____

Have you made regular dental visits? Yes ◯ No ◯ How often? _____

When were dental x-rays last taken? _____

Do you have well water (private)?	Yes ◯	No ◯
Does your water have fluoride in it?	Yes ◯	No ◯
Have you ever been treated for gum disease?	Yes ◯	No ◯
Do you clench or grind your teeth?	Yes ◯	No ◯
Does your jaw click or pop?	Yes ◯	No ◯
Have you experienced any pain or soreness in the muscles of your face or ears?	Yes ◯	No ◯
Are you interested in a complimentary evaluation for temporomandibular joint (TMJ) concerns?	Yes ◯	No ◯
Do you have dental implants?	Yes ◯	No ◯
Do you have any REMOVABLE partials or dentures?	Yes ◯	No ◯

Have you ever been told you have periodontal disease? Yes ◯ No ◯

Have you had any non-surgical or surgical periodontal treatment done? Yes ◯ No ◯

If **Yes**, when? _____

Would you like a whiter smile? Yes ◯ No ◯

Have you had any orthodontic treatment? Yes ◯ No ◯

Are you interested in a complimentary orthodontic evaluation? Yes ◯ No ◯

Are you concerned with your breath? Yes ◯ No ◯

What would you like to change about your smile?

_____

Have you had any bad experiences with dental treatment that you would like to share with us?

Patient or Guardian Signature:

Note: If filling out this Form via the Web or Email, you will be asked to sign at our office at your appointment.