

## JASON M GRINTER DDS PC

### MEDICAL AND DENTAL HISTORY FORM

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Date of Last Medical Visit \_\_\_\_\_

Reason for medical visit \_\_\_\_\_

1. Is patient currently under the care of a medical doctor?  Yes  No Reason \_\_\_\_\_

2. Is patient taking any medications?  Yes  No

If yes, list drugs: a. \_\_\_\_\_ Reason \_\_\_\_\_

b. \_\_\_\_\_ Reason \_\_\_\_\_

c. \_\_\_\_\_ Reason \_\_\_\_\_

#### **You may alternatively provide current Medication Administration Record (MAR)**

3. Is patient allergic to penicillin?  Yes  No

4. Is patient allergic to other medications?  Yes  No

If yes, please state name of drug/reaction: \_\_\_\_\_

5. FEMALES: Is there any possibility patient is pregnant?  Yes  No

If yes, how many months? \_\_\_\_\_ Taking birth control pills  Yes  No

6. Does patient have or ever had any of the following?	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Heart disease, heart murmur, or heart surgery	___	___	_____
Bleeding or blood clotting problems/diseases	___	___	_____
Diabetes (blood sugar problems)	___	___	_____
Sickle cell anemia or trait	___	___	_____
Thyroid problems	___	___	_____
Convulsions/seizures or fainting spells	___	___	_____
Tuberculosis	___	___	_____
Hepatitis or other liver problems	___	___	_____
Kidney problems	___	___	_____
Asthma or wheezing	___	___	_____
Cancer, leukemia, other tumor	___	___	_____
Birth defects, or genetic defects	___	___	_____
HIV and/or AIDS	___	___	_____
Drug and/or alcohol dependency	___	___	_____
Received steroid treatment	___	___	_____
Mental retardation or delay in normal development	___	___	_____
Cigarette or smokeless tobacco use	___	___	_____

7. Does patient have a history of, or is currently suffering from a medical condition not mentioned above?  
 Yes  No

If yes, what is the medical condition? \_\_\_\_\_

8. Has patient's doctor recommended any special precautions for dental treatment?  Yes  No

If yes, what precautions? \_\_\_\_\_

9. Indicate if patient has any of these:  Blindness  Hearing Problems  Speech Problems

#### **PATIENT'S DENTAL HISTORY**

1. Reason you are seeking dental care for patient \_\_\_\_\_

2. Has patient ever been to a dentist before?  Yes  No If yes, name of dentist \_\_\_\_\_

3. Has patient ever had any of the following?	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Injuries to the mouth or teeth?	___	___	_____
Toothache and/or abscesses?	___	___	_____

4. Does patient have any of the following habits?	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Finger, thumb or pacifier sucking?	___	___	_____
Mouth breathing?	___	___	_____

5. Do you think patient receives proper daily dental care?  Yes  No

6. What type of water does patient drink?  Community tap water  Well water  Bottled water

7. Other dental information we should know? \_\_\_\_\_

**PATIENT'S SOCIAL AND BEHAVIORAL HISTORY**

1. Do you think patient will cooperate for dental treatment?      \_\_\_ Yes    \_\_\_ No

2. Has patient ever had a 'bad' or 'fearful' medical or dental treatment?    \_\_\_ Yes    \_\_\_ No

3. Does patient have any history of emotional or behavioral problems?    \_\_\_ Yes    \_\_\_ No

Is there any additional information we should know? \_\_\_\_\_

---

**I certify that I have read and understood the above questions. To the best of my knowledge the above information is correct. I will not hold the treating dentist(s) or any member of the dental staff responsible for any errors or omissions I may have made in the completion of this form. I understand that it is my responsibility to inform my patient's dentist when there is a change in my patient's medical condition, or when there is a change in the responses to any of the above questions.**

**PERSON COMPLETING THIS FORM:** \_\_\_\_\_ **SIGNATURE** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**Are you legally responsible for this patient?** \_\_\_\_\_

These forms are meant for legal guardians to sign, if you are a facility agent and have authority to make medical decisions for your patient, please provide a copy of that document for our records.

**Patients with Office of State Guardian (OSG) guardianship must have this consent signed by OSG prior to the appointment**