Greater Elgin Family Care Center

DENTAL / MEDICAL HISTORY

PATIENT NAME _____ DATE OF BIRTH _____

Person completing this form (if other than patient) _____ Relationship _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

What is the main reason for your visit today? _____

Please circle the appropriate answer.
Are you allergic to any food or medications? YES NO If yes, please explain: _____

Have you been pre-medicated before any dental procedures? YES NO If yes, please explain: _____

For female patients: Are you pregnant? YES NO Are you nursing? YES NO Are you taking oral contraceptives? YES NO

Are you taking any medications? This includes prescribed, over the counter, and herbal medications. YES NO

If yes, please list: _____

Do you have, or have you had, any of the following?

Please circle the appropriate answer.

ADHD	YES	NO
AIDS / HIV positive	YES	NO
Artificial heart valve	YES	NO
Artificial joint	YES	NO
Bleeding disorder	YES	NO
Bulimia	YES	NO
Cancer	YES	NO
Developmental problems	YES	NO
Diabetes	YES	NO
Epilepsy or seizures	YES	NO
Heart disease	YES	NO
Heart murmur	YES	NO
Heart pacemaker	YES	NO
Hepatitis	YES	NO
High blood pressure	YES	NO
Mitral valve prolapse	YES	NO
Osteoporosis	YES	NO
Pregnancy	YES	NO
Tobacco use	YES	NO
Tuberculosis	YES	NO

Have you ever had any serious illness not listed on this form? YES NO

If yes, please explain:

Comments: