Dental Medical History Form

Our **dental medical history form sample** is designed specifically for clinics to efficiently gather essential patient health information. This form ensures accurate documentation of medical background, allergies, and previous dental treatments. It helps dental professionals provide safe and personalized care to every patient.

Patient Name:

Date of Birth:

Gender:

☐ Male ☐ Female ☐ Other

Phone Number:

Address:

Medical History	
Are you currently under the care of a physician?	☐ Yes ☐ No If yes, explain:
Do you have any allergies? (medications, latex, food, etc.)	☐ Yes ☐ No If yes, please list:
Have you ever had any of the following? (Check all that apply)	☐ Heart Disease ☐ Diabetes ☐ High Blood Pressure ☐ Asthma ☐ Bleeding Disorder ☐ Hepatitis ☐ Epilepsy ☐ Other:
Are you currently taking any medications?	☐ Yes ☐ No If yes, please list:
Do you smoke or use tobacco?	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No ☐ N/A

Dental History	
Reason for today's visit:	
Do you have dental pain or discomfort?	☐ Yes ☐ No

Have you had any complications from previous dental treatments?	☐ Yes ☐ No If yes, please describe:
How often do you brush and floss?	
Date of last dental visit:	

Emergency Contact Name and Phone:

Signature:

Date:

Note: All information provided is kept strictly confidential and used only for your health and safety during dental care. If unsure about any question, please discuss with your dental provider.