Mobile Dental Hygiene

Medical Dental History Form

Patient Name _____ Date of Birth _____
Dentist's Name (if you have one) _____Phone (___) _____
Reason for today's visit _____Date of last dental care_____

Physician's name_____ Phone (___) _____
Please describe medical condition or current long-term disability, if any:

_____

Has antibiotic Pre-med been needed for dental treatment in the past? Y/N/unknown

Check (√) if you have problems with any of the following:

□ Pain/Discomfort	□ Partials or Dentures	□ Bleeding While Brushing
□ Sores/Growths in Mouth	□ Dry mouth	□ Sensitivity to Hot/Cold
□ Food Collection Between Teeth	□ Bad Breath/Taste	□ Sensitivity to sweets
	□ Other_____	

Check (√) if you have any of the following: □ Blind □Deaf □Disabled
□Parkinson's □Alzheimer's □Cerebral Palsy □Multiple Sclerosis □Dementia

□Anemia	□Diabetes	□HIV/AIDS	□Shortness of Breath
□Arthritis, Rheumatism	□Drug Addiction	□Jaw Pain	□Skin Rash
□Artificial Heart Valves	□Epilepsy/Seizures	□Kidney Disease	□Stroke
□Artificial Joints	□Excess Bleeding	□Liver Disease	□Swelling of Ankles
□Asthma	□Fainting	□Pacemaker	□Thyroid Problems
□Back Problems	□Glaucoma	□Persistent Cough	□Tobacco Use
□Cancer	□ Headaches	□Radiation Treatment	□Tonsillitis
□Chemotherapy	□Heart Problems	□Respiratory Disease	□Tuberculosis
□Chemical Dependency	□Hepatitis	□Rheumatic Fever	□Ulcers
□Circulatory Problems	□High Blood Pressure	□Scarlet Fever	

Please List **ALL MEDICATIONS** you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies: □Latex □Sulfa □Aspirin □Penicillin □Local anesthetic □Codeine □Others

Pharmacy name: _____ Phone#:_____

The above information is accurate and complete to the best of my knowledge. I will not hold Danyelle Evans, RDH and Mobile Dental Hygiene or any member of the staff responsible for any errors or omissions in the completion of this form.

Signature: _____Date:_____
Name: _____ Relationship to Patient: _____