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

Please use [TAB] key or MOUSE to navigate through the Form.

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 diseases or problems:

(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 & 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 ☐
Aneurism 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 ☐
Lymes 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 you 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 your ears?	Yes ◯	No ◯
Are you interested in a complimentary evaluation for temporomandibular joint (TMJ) concerns?	Yes ◯	No ◯
Do you have any 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 ◯

Are you interested in a complimentary evaluation for snoring? 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 relate to 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.

Please do NOT fill out section below,
but continue to scroll to the bottom of this page to [SAVE] / [SUBMIT]

(This section is for *FUTURE* appointments)

HEALTH UPDATES:

- **Current Date:** _____

Have there been any changes in your medical or dental History? **Yes** ◯ **No** ◯

Please Explain:

Patient or Guardian Signature:

Doctor/Provider Signature:

❖ **If you are submitting this Form via Email or the WEB:**

If you use Microsoft Outlook or Outlook Express/Windows Mail as your *default* email, click [Submit].

If you do not have Outlook setup on your computer, 'SAVE' this Form to your computer and send as an *attachment* through your regular email to:

staff@baraboodental.com

SAVE

SUBMIT