Short Form Medical History

Date: __________________

Chart #: __________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Gender: ________
Last, First MI (Preferred Name)

Social Security #: ____________________ Birth Date: ____________________ Driver's License #: ____________
(Optional)

Home Phone: ________________ Work Phone: ____________ Ext:______ Mobile/Pager: ______________

Address: ____
Street Apartment

____
City State Zip Code

E-mail: ____

School Information

School Name: ______________________________ Sports You Play: ____________________

Address: ____
Street City, State Zip Code Phone

Have you had any dental related sports injuries? ☐ Yes ☐ No Explain: ____________________________
____

Health Information

•**Are you allergic to any of the following (please check all that apply): ☐ Yes ☐ No**
☐ Penicillin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin; ☐ Codeine; ☐ Latex; ☐ Metals; ☐ Dental Anesthetics; ☐ Other

Have you ever had any of the following? Please answer Yes or No to each question by marking the boxes below.

Y N		Y N		Y N		Y N	
☐ ☐	Anemia	☐ ☐	Respiratory Disease	☐ ☐	Cancer	☐ ☐	Dizziness/Fainting
☐ ☐	Heart Disease	☐ ☐	Tuberculosis	☐ ☐	Growths/Tumors	☐ ☐	Epilepsy/Seizures
☐ ☐	High Blood Pressure	☐ ☐	Asthma	☐ ☐	Chemotherapy	☐ ☐	Mental Disorders
☐ ☐	Heart Murmur	☐ ☐	Hay Fever	☐ ☐	Radiation Treatment	☐ ☐	Nervous Disorders
☐ ☐	Stroke	☐ ☐	Allergies	☐ ☐	Hepatitis Type:	☐ ☐	Anxiety
☐ ☐	Artificial Joints	☐ ☐	Sinus Problems	☐ ☐	Jaundice	☐ ☐	Depression
☐ ☐	MitralValve Prolapse	☐ ☐	Diabetes	☐ ☐	Liver Disease	☐ ☐	Drug Addiction
☐ ☐	Rheumatic Fever	☐ ☐	Blood Disease	☐ ☐	Kidney Disease	☐ ☐	Head Injuries
☐ ☐	Pacemaker	☐ ☐	Excessive Bleeding	☐ ☐	Rheumatism	☐ ☐	Cold Sores
☐ ☐	Heart Attack	☐ ☐	Hemophilia	☐ ☐	Glaucoma	☐ ☐	Frequent Headaches
☐ ☐	Angina Pectoris	☐ ☐	Bruise Easily	☐ ☐	HIV/AIDS	☐ ☐	TMJ
☐ ☐	Blood Transfusion	☐ ☐	Ulcers	☐ ☐	Arthritis	☐ ☐	Pain in Jaw Joints

• Do you have any other health problems or conditions? ☐ Yes ☐ No
If yes, please explain: ____

•Are you taking any medications at this time? ☐ Yes ☐ No
If yes, please list : ____

• Have you been admitted to a hospital or needed emergency care during the past year? ☐ Yes ☐ No
If yes, please explain: ____

• Are you now under the care of a physician? ☐ Yes ☐ No Name of Physician: ____________________ Phone:___________

• Do you smoke? ☐ Yes ☐ No • Have you ever taken any diet drugs such as Phen-Phen, Redux, other? ☐ Yes ☐ No

• Women: are you pregnant now? ☐ Yes, Due Date: ______ ☐ No • Do you take any birth control medication? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

√____ **Date:** ____________________
Signature of patient, parent or guardian

AFFINITY
DENTAL CENTER

Sports Guard Program Survey & Dental History

This program is currently supported by local and national sponsors looking to make a difference in dental related sports accidents and injuries in the community. **Affinity Dental Center** welcomes your feedback and your answers will be kept confidential. Thank you for your participation.

Sports

What sports do you currently participate in?

○ Football ○ Baseball ○ Basketball ○ Soccer ○ Other: ____________________

Does the school or league recommend a protective sports guard?

○ Yes ○ No

Do you think your school or league would benefit from the 'Free Sports Guard Program'?

○ Yes ○ No

If Yes, would you like information or could you share the names of the contact people responsible for the program:____

Dental History

Do you currently have an existing dentist?

○ Yes ○ No If Yes, Name and City:______________________________________

When was the last time you were in for a check-up?

○ 1 month ○ 3-6 months ○ 6-12 months ○ 12 or more months

Have you had braces or any other type of corrective alignment?

○ Yes ○ No If Yes, how long ago:______________________________________

Have you or your child ever been told you need braces or Invisalign?

○ Yes ○ No If Yes, how long ago:______________________________________

Have you ever had a dental injury because of playing sports?

○ Yes ○ No

If Yes, how long ago & what happened:____

Is your current Dentist providing you and your family with the level of care you expect?

○ Yes ○ No

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Additional Feedback

Please share any additional comments.

____
____
____
____
____
____
____

Personal Information

Providing the following information is optional.

First Name: ______________________ Last Name: ______________________

Address: ____

City: ______________________ State: ______________ ZIP Code: __________

Telephone: ______________________ Gender: ______________ Age: __________

Would you like someone to contact you regarding your responses on this survey?

○ Yes ○ No

Thank you for taking the time to fill out our survey. We rely on your feedback to help us continue to offer this program to the community. Your input is greatly appreciated.