FAMILY HISTORY DISCOVERY FORM

_____ _____

Patient Name **Date**

Family Medical History

Please circle any condition that applies to your parents:

Heart Disease Stroke High Blood Pressure Heart Attack Use Dentures

Pre-term birth Gum Disease Tooth Loss Diabetes

Are both your parents still alive? YES / NO What ages did they pass? _____

At what age were they diagnosed with these conditions? _____

Do you recall your parents taking medications? YES / NO For how long? _____

Do you have siblings? YES / NO Are they also suffering the same symptoms? YES / NO

_____ _____

Signature of patient Date

For completion by Dentist

Comments on patient interview_____

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_____

Significant findings from questionnaire: _____

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Dental Management Considerations: _____

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Signature of Dentist