Medical History

Patient's Name:_________________________________ **Birthdate**:_____________ **Preferred Name**:_______________

Cell Phone: _______________________ **Email Address**: ____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Physician: _____________________________________ Physician Phone:___________________________

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, explain: ____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, explain: ____

In Case of Emergency Contact: _________________________ Relationship: ____________ Phone: _________________

How did you hear about our Office? ____

Do you have or have you had any of the following?

☐ AIDS/ HIV Positive
☐ Acid Reflux/ GERD
☐ Allergies
☐ Alzheimer's Disease
☐ Anemia Chronic
☐ Angina Pectoris
☐ Antipsychotic Medications
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joint Type:_____________ When:_________
☐ Asthma
☐ Bleeding Disorder
☐ Cancer Type:_______________________________
☐ Chemical Dependency/ Alcohol/ Drugs
☐ Coagulation Disorder
☐ Congenital Heart Defect
☐ Crohn's Disease
☐ Depression
☐ Diabetes
☐ Epilepsy, Seizures, or Fainting Spells
☐ Glaucoma
☐ Hearing Impaired
☐ Heart Attack/ Congestive Heart Failure
☐ Heart Murmur
☐ Heart Valve Replacement
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Kidney Disease
☐ Kidney Dialysis
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lupus
☐ Meniere's Disease
☐ Mental Disorder
☐ Mitral Valve Prolapse
☐ Neck & Back Problems
☐ Organ Transplant
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation/ Chemotherapy When?___________
☐ Respiratory Problems
☐ Rheumatic Fever/ Rheumatic Heart Disease
☐ Rheumatism
☐ Shingles
☐ Sinus Problems
☐ Spina Bifida
☐ Stomach Problems
☐ Stroke When?________________
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease/ STD's

Do you have any condition or disease that is not listed above? ☐ Yes ☐ No

If yes, please explain: ____

List any **Medications, Over the Counter Medications, Supplements or Herbs** that you are currently taking:

Prescriptions Meds	Over the Counter Meds	Supplements	Herbs
______________________	_____________________	___________________	_________________
______________________	_____________________	___________________	_________________
______________________	_____________________	___________________	_________________
______________________	_____________________	___________________	_________________

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:____

Are you **Allergic**, or have you reacted adversely to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Penicillin ☐ Sulfa Drugs

☐ Tetracycline ☐ Other ____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No If yes, please explain: __________________________________

Are you taking Bisphosphonates for osteoporosis or cancer treatment: ☐ Yes ☐ No ☐ Don't Know

Women: Pregnant? ☐ Yes ☐ No If yes, expected delivery date:____

Trying to get pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Taking Hormones or Contraceptives? ☐ Yes ☐ No

Dental History

Reason for today's visit? ____

Are you experiencing any dental pain today? ☐ Yes ☐ No

If yes, explain:____

Date of last Dental Visit:___________________________ **Date of last Dental Cleaning:** _______________________________

Have you ever been told that you require antibiotics before dental appointments? ☐ Yes ☐ No

If yes, explain: ____

Do you have or have you experienced any of the following?:

Dry Mouth ☐ Yes ☐ No

Sensitive Teeth ☐ Yes ☐ No

Sensitive to what? ☐ Hot ☐ Cold ☐ Pressure ☐ Sweets

Cold Sores/ Blisters/ Oral Lesions ☐ Yes ☐ No

Loose Teeth ☐ Yes ☐ No

Jaw Pain or Jaw Noise ☐ Yes ☐ No

Clenching/ Grinding Teeth ☐ Yes ☐ No

Complications from Dental Extractions ☐ Yes ☐ No

Periodontal/ Gum Surgery ☐ Yes ☐ No

A Mouth Guard ☐ Yes ☐ No

Do you Snore or have Sleep Apnea? ☐ Yes ☐ No

Bleeding Gums ☐ Yes ☐ No

If you could change something about your smile, what would it be?:

☐ Whiter

☐ Straighter

☐ Close Space

☐ Replace Mercury fillings with tooth colored fillings

☐ Repair chipped teeth

☐ Replace missing teeth

☐ Replace Old Crowns or Caps that don't match

☐ Less Gums showing

☐ Other explain:____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient (Parent if Minor or Legal Guardian): __________________________________ **Date:**_____________

Doctor Signature: _______________________________________ **Date:** ___________________________