

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:		First Name:	Middle Name:
Home Phone:		Cell Phone:	Work Phone:
Email Address:			
Mailing Address:		City:	State: Zip:
Date of Birth: / /		Gender:	
Occupation:			
Emergency Contact: Name:		Relationship:	Phone:
If you are completing this form for another person, what is your name and relationship to that person? Name: Relationship:			
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?			
When was your last dental exam? / /		What was done at that appointment?	
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth? <input type="checkbox"/>		Have you ever had a serious injury to your head or mouth? <input type="checkbox"/>	
Does it hurt to chew, bite or swallow? <input type="checkbox"/>		If yes, please describe what happened and when it happened: _____	
Do your gums bleed when you brush or floss your teeth? <input type="checkbox"/>		Have you ever had problems with dental treatment in the past? <input type="checkbox"/>	
Have you ever had periodontal (gum) treatments like scaling and root planing? <input type="checkbox"/>		If yes, please describe what happened: _____	
Do you have, or have you ever had, any sores or growths in your mouth? <input type="checkbox"/>		Have you ever had a reaction to, or problem with, dental anesthesia? <input type="checkbox"/>	
Do you clench or grind your teeth? <input type="checkbox"/>		If yes, please describe what happened: _____	
Does your jaw click, pop or hurt? <input type="checkbox"/>		Are you unhappy with your smile? <input type="checkbox"/>	
Do you have earaches or neck pains? <input type="checkbox"/>		If yes, why? Please mark all that apply:	
Does dental treatment make you nervous? <input type="checkbox"/>		<input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth	
Have you ever experienced any of these sleep-related breathing disorders? <input type="checkbox"/>		<input type="checkbox"/> Other. Please describe: _____	
<input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep			
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions. Yes No ?			
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, what medication are you taking? _____			
Are you taking any medication to treat osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking hormonal replacements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use vaping products ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
How many alcoholic beverages do you have per week? _____			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, please list them here and include information about how much and how often you use each one. _____			
WOMEN ONLY: Are you:			
Taking birth control pills ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Pregnant? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Nursing? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:

Yes No ?

Aspirin ☐ ☐ ☐

Barbiturates, sedatives or sleeping pills ☐ ☐ ☐

Codeine or other narcotics ☐ ☐ ☐

Hay fever/seasonal allergies ☐ ☐ ☐

Iodine ☐ ☐ ☐

Latex (rubber) ☐ ☐ ☐

Local anesthetics ☐ ☐ ☐

Metals ☐ ☐ ☐

Penicillin or other antibiotics ☐ ☐ ☐

Yes No ?

Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix). ☐ ☐ ☐

Other ☐ ☐ ☐

Please describe any "Yes" answers and include information about your experience. _____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.

Yes No ?

Are you in good physical health? ☐ ☐ ☐

Are you currently being seen or treated by a physician? ☐ ☐ ☐

Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done? ☐ ☐ ☐

Have you had a **serious illness, operation or been hospitalized** in the past 5 years? ☐ ☐ ☐

Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)? ☐ ☐ ☐

Have you had a **heart valve replacement or heart surgery**? ☐ ☐ ☐

Have you had an **organ or bone marrow/stem cell transplant**? ☐ ☐ ☐

Have you traveled internationally within the last 30 days ☐ ☐ ☐

Have you had a fever (100.4°F or above) in the last 72 hours? ☐ ☐ ☐

If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

Yes No ?

Yes No ?

Yes No ?

Heart (Cardiac) Health

Pacemaker/implanted defibrillator ☐ ☐ ☐

Artificial (prosthetic) heart valve ☐ ☐ ☐

Previous infective endocarditis ☐ ☐ ☐

Congenital heart disease (CHD) ☐ ☐ ☐

Unrepaired, cyanotic CHD ☐ ☐ ☐

Repaired (completely) in last 6 months ☐ ☐ ☐

Repaired CHD with residual defects ☐ ☐ ☐

Arteriosclerosis ☐ ☐ ☐

Coronary artery disease ☐ ☐ ☐

Congestive heart failure ☐ ☐ ☐

Damaged heart valves ☐ ☐ ☐

Heart attack ☐ ☐ ☐

Heart murmur/rhythm disorder ☐ ☐ ☐

Rheumatic heart disease ☐ ☐ ☐

Stroke ☐ ☐ ☐

Cancer

Type: _____

Date of diagnosis: _____

Chemotherapy: _____

Radiation treatment: _____

Blood (Circulatory) Health

Anemia ☐ ☐ ☐

Blood transfusion ☐ ☐ ☐

If yes, date: _____

Hemophilia ☐ ☐ ☐

High or low blood pressure ☐ ☐ ☐

Brain (Neurological)/Mental Health

Anxiety ☐ ☐ ☐

Depression ☐ ☐ ☐

Epilepsy ☐ ☐ ☐

Mental health disorders ☐ ☐ ☐

Neurological disorders ☐ ☐ ☐

Post-traumatic stress disorder ☐ ☐ ☐

Traumatic brain injury or concussion ☐ ☐ ☐

Autoimmune Disease

AIDS or HIV Infection ☐ ☐ ☐

Lupus ☐ ☐ ☐

Digestive Health

Gastrointestinal disease ☐ ☐ ☐

G.E. reflux/persistent heartburn (GERD) ☐ ☐ ☐

Stomach ulcers ☐ ☐ ☐

Eye (Vision) Health

Glaucoma ☐ ☐ ☐

Other

Arthritis ☐ ☐ ☐

Chronic pain ☐ ☐ ☐

Diabetes (type I or II) ☐ ☐ ☐

Eating disorder ☐ ☐ ☐

Frequent infections ☐ ☐ ☐

Type of infection: _____

Hepatitis, jaundice or liver disease ☐ ☐ ☐

Immune deficiency ☐ ☐ ☐

Kidney problems ☐ ☐ ☐

Malnutrition ☐ ☐ ☐

Osteoporosis ☐ ☐ ☐

Rheumatoid arthritis ☐ ☐ ☐

Sexually transmitted infection (STI) ☐ ☐ ☐

Thyroid problems ☐ ☐ ☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:

Yes No ?

Yes No ?

Yes No ?

had pain or tightness in the chest? ☐ ☐ ☐

coughed up blood or had a cough that lasted longer than 3 weeks? ☐ ☐ ☐

been exposed to anyone with tuberculosis? ☐ ☐ ☐

had a rapid or irregular heart beat? ☐ ☐ ☐

found it hard to catch your breath? ☐ ☐ ☐

had a high fever (greater than 101.5°F) for no reason? ☐ ☐ ☐

noticed a change in your vision? ☐ ☐ ☐

fainted for no reason? ☐ ☐ ☐

experienced vomiting, diarrhea, chills, night sweats or bleeding? ☐ ☐ ☐

had migraines or severe headaches? ☐ ☐ ☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____