Medical History ALL PATIENTS - 2021

Patient Name: Birth Date: Date Created:

General Medical History

Do you have a primary care physican?	○ Yes ○ No	If yes
Have you been hospitalized or had a surgery in the last 2 years? (PLEASE LIST)	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs? (PLEASE LIST)	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you smoke, vape, use smokeless tobacco or any other controlled substances?	○ Yes ○ No	If yes
Are you undergoing any medical treatment at this time?	○ Yes ○ No	If yes

General List Questions

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Acrylic	☐ Codeine	☐ Iodine	☐ Latex
☐ Local Anesthetic	☐ Metal	☐ Penicillin	☐ Sulfa Drugs

Other allergies not listed here? ○ Yes ○ No If yes

Conditions or Disorders

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

AIDS/HIV Positive	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Anemia	○ Yes ○ No
Angina/Chest Pain	○ Yes ○ No	Anxiety/Depression	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Asthma/Breathing Trouble	○ Yes ○ No	Blood/Clotting Disorder	○ Yes ○ No	Blood Transfusion	○ Yes ○ No
Cancer	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No
Diabetes	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Edema/Swelling of Limbs	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No
Excessive Thirst/Dry Mouth	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	GERD/Acid Reflex	○ Yes ○ No
Heart Attack/Failure	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Herpes/Cold Sores	○ Yes ○ No
Hepatitis A,B or C	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Hypoglycemia	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No	Kidney Disease	○ Yes ○ No	Leukemia	○ Yes ○ No	Liver Disease	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Lung Disease	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Pain in Jaw Joints	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Rheumatism	○ Yes ○ No
Shingles	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Tonsillitis	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Tumors or Growths	○ Yes ○ No

Are there any other physical, mental or emotional conditions we should be aware of? ○ Yes ○ No If yes

CHILDREN

Please answer for your child:

Uses baby bottle	○ Yes ○ No	Uses a pacifier	○ Yes ○ No
Sucks finger/thumb	○ Yes ○ No	Has had orthodontic treatment	○ Yes ○ No
Has had poor dental expierences	○ Yes ○ No	Takes a fluoride supplement	○ Yes ○ No

Is there anything else we should know about your child? ○ Yes ○ No If yes

DENTAL HISTORY

Date of last dental visit and reason for visit — Comment

Who was your previous dentist? — Comment

How often do you floss?

How often do you brush?

Do your gums bleed? When? — Yes / No — If yes

Have you ever been told that you have periodontal (gum) disease? — Yes / No — If yes

Have you ever been referred for or undergone periodontal surgery? — Yes / No — If yes

Have you ever had any other dental or facial surgery? — Comment

Do you clench or grind your teeth? — Yes / No

Are your teeth sensitive to:

- [ ] Hot
- [ ] Cold
- [ ] Sweet
- [ ] Chewing

Do you have any removable appliances in/for your mouth?

- [ ] Full denture
- [ ] Partial denture
- [ ] Night guard
- [ ] Snore Guard
- [ ] Retainer
- [ ] Oral Piercings

Is there anything about the appearance or function of your teeth that you would like to change? — Yes / No — If yes

Do you feel nervous about having dental treatment? — Yes / No — If yes

Emergency Contact

In case of emergency, who should we contact? Please list First and Last name, relationship and phone number — Comment

Signature

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

Signature of Patient, Parent or Guardian:

X

Date:_____