

# 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"/> Does it hurt to chew, bite or swallow? ..... <input type="checkbox"/> Do your gums bleed when you brush or floss your teeth? ..... <input type="checkbox"/> Have you ever had periodontal (gum) treatments like scaling and root planing? ..... <input type="checkbox"/> Do you have, or have you ever had, any sores or growths in your mouth? ..... <input type="checkbox"/> Do you clench or grind your teeth? ..... <input type="checkbox"/> Does your jaw click, pop or hurt? ..... <input type="checkbox"/> Do you have earaches or neck pains? ..... <input type="checkbox"/> Does dental treatment make you nervous? ..... <input type="checkbox"/> Have you ever experienced any of these sleep-related breathing disorders? ..... <input type="checkbox"/> <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep	Have you ever had a serious injury to your head or mouth? ..... <input type="checkbox"/> If yes, please describe what happened and when it happened: _____ _____ Have you ever had problems with dental treatment in the past? ..... <input type="checkbox"/> If yes, please describe what happened: _____ _____ Have you ever had a reaction to, or problem with, dental anesthesia? ..... <input type="checkbox"/> If yes, please describe what happened: _____ _____ Are you unhappy with your smile? ..... <input type="checkbox"/> If yes, why? Please mark all that apply: <input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth <input type="checkbox"/> Other. Please describe: _____		
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions.			Yes No ?
Are you taking any <b>blood thinners</b> (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 <b>osteoporosis</b> 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 <b>IV medication</b> 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 <b>hormonal replacements</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use any form of <b>tobacco or nicotine products</b> (cigarettes, cigars, snuff, chew, bidis)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use <b>vaping products</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
How many <b>alcoholic beverages</b> do you have per week? _____			
Do you use <b>controlled substances</b> (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 <b>prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements</b> ? ..... <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. _____			
<b>WOMEN ONLY:</b> Are you:			
Taking <b>birth control pills</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>Pregnant?</b> If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>Nursing?</b> 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	?	Yes	No	?
Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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). . . . . <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Barbiturates, sedatives or sleeping pills .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other .....		
Codeine or other narcotics .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please describe any "Yes" answers and include information about your experience. _____		
Hay fever/seasonal allergies .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Latex (rubber) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Local anesthetics .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Metals .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Penicillin or other antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

**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? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently being seen or treated by a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take <b>antibiotics</b> before having dental work done? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a <b>serious illness, operation or been hospitalized</b> in the past 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any type (either total or partial) of <b>joint replacement surgery</b> (such as for a hip, knee, shoulder, elbow, finger, etc.)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a <b>heart valve replacement or heart surgery</b> ? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an <b>organ or bone marrow/stem cell transplant</b> ? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled internationally within the last 30 days .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a fever (100.4°F or above) in the last 72 hours? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	?
<b>Heart (Cardiac) Health</b>					<b>Digestive Health</b>		
Pacemaker/implanted defibrillator .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Gastrointestinal disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial (prosthetic) heart valve .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		G.E. reflux/persistent heartburn (GERD) .....	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Stomach ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<b>Eye (Vision) Health</b>		
Unrepaired, cyanotic CHD .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<b>Other</b>		
Repaired CHD with residual defects .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic pain .....	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes (type I or II) .....	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Eating disorder .....	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Frequent infections .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Type of infection: _____		
Heart murmur/rhythm disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis, jaundice or liver disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Immune deficiency .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Kidney problems .....	<input type="checkbox"/>	<input type="checkbox"/>
					Malnutrition .....	<input type="checkbox"/>	<input type="checkbox"/>
					Osteoporosis .....	<input type="checkbox"/>	<input type="checkbox"/>
					Rheumatoid arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
					Sexually transmitted infection (STI) .....	<input type="checkbox"/>	<input type="checkbox"/>
					Thyroid problems .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Breathing (Respiratory) Health</b>							
Asthma (COPD) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Bronchitis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sinus trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Cancer</b> .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Type: _____							
Date of diagnosis: _____							
Chemotherapy: _____							
Radiation treatment: _____							
<b>Blood (Circulatory) Health</b>							
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Blood transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
If yes, date: _____							
Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
High or low blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Brain (Neurological)/Mental Health</b>							
Anxiety .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Depression .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Mental health disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Neurological disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Post-traumatic stress disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Traumatic brain injury or concussion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Autoimmune Disease</b>							
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Lupus .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	found it hard to catch your breath? .....	<input type="checkbox"/>	<input type="checkbox"/>	experienced vomiting, diarrhea, chills, night sweats or bleeding? .....	<input type="checkbox"/>	<input type="checkbox"/>
coughed up blood or had a cough that lasted longer than 3 weeks? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	had a high fever (greater than 101.5°F) for no reason? .....	<input type="checkbox"/>	<input type="checkbox"/>	had migraines or severe headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>
been exposed to anyone with tuberculosis? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	noticed a change in your vision? .....	<input type="checkbox"/>	<input type="checkbox"/>			
had a rapid or irregular heart beat? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fainted for no reason? .....	<input type="checkbox"/>	<input type="checkbox"/>			

**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: \_\_\_\_\_