MEDICAL & DENTAL HISTORY

PATIENT INFORMATION Today's Date_____/_____/__________

Patient Name: ____ Date of Birth: _____/_____/__________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Partnership

Address__________________________________City__________________State______Zip Code______________

Home Phone____________________ Cell Phone ___________________Email__________________________________

MEDICAL HISTORY

Your physician: ____ Date of last visit: _______/_______/__________

Are you under medical treatment now? ☐ Yes ☐ No If yes, what treatment? _____________________________

Have you been hospitalized in the last 2 years or had any major operations or serious illnesses? ☐ Yes ☐ No

If yes, please describe: ____

Women only: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Do you currently (or have you ever had) any of the following conditions? (Check all that apply):

____ Acid reflux	____ Chemical dependency	____ Heart disease	____ Rheumatic fever
____ Anemia	____ Chemotherapy	____ Hepatitis/Liver	____ Sexually transmitted disease
____ Arthritis	____ Circulatory problems	____ High blood pressure	____ Sleep apnea
____ Artificial heart valves	____ Congenital heart lesions	____ HIV AIDS	____ Stroke
____ Artificial joints	____ Diabetes	____ Jaw pain	____ Swelling of feet or ankles
____ Asthma	____ Epilepsy/Convulsions	____ Kidney problems	____ Thyroid problems
____ Bleeding disorder	____ Fainting/Seizure	____ Low blood pressure	____ Tobacco use
____ Blood disease	____ Glaucoma	____ Osteoporosis	____ Tonsillitis
____ Bone disorder	____ Headache	____ Radiation treatment	____ Tuberculosis (TB)
____ Cancer/Tumor	____ Heart murmur	____ Respiratory disease	____ Ulcer
____ Other ______________________________			

Check if you are ***ALLERGIC*** to any of the following:

____ Penicillin	____ Latex	____ Codeine	____ Sulfa Drugs
____ Aspirin	____ Local Anesthetic	____ Other ____________________________	

Have you ever taken medications (such as bisphosphonates) that affect bone or to prevent bone disease (ie. Fosamax, Zometa, Actonel, Aredia)? ☐ Yes ☐ No

Has your physician ever recommended that you be pre-medicated with antibiotics before dental treatment (ie. Joint replacement, history of infective endocarditis)? ☐ Yes ☐ No If Yes, reason: _____________________________

Thank you for selecting our dental healthcare team and taking the time to fill out this form, please see the next page for some important information – we appreciate it very much!

MEDICAL & DENTAL HISTORY

Are you currently taking any Medications? ☐ Yes ☐ No If Yes, please list all medications below:

Medication	Diagnosis

DENTAL HISTORY

Reason for today's visit: ____

Date of last dental care visit: _______/_______/__________ Date of last dental x-rays: _______/_______/__________

Former Dentist Name: ____ Office Phone ____________________________

Check if you have any problem with the following:

____ Bad breath ____ Food collection between the teeth ____ Loose teeth or broken fillings

____ Bleeding gums ____ Grinding teeth ____ Mouth breathing

____ Blisters on Lips/Mouth ____ Gums swollen or tender ____ Periodontal treatment

____ Chew on one side of your mouth ____ Jaw pain ____ Sores in your mouth

____ Clicking or popping jaw ____ Lip or cheek biting ____ Toothache

Are you sensitive to any of the following: cold, hot, sweets, chewing or when biting? _____________________________

How often do you brush? ____________________________How often do you floss? _____________________________

What is your main concern with dental treatment? (ie. Time, Expense, Fear, etc) _________________________________

What is your main concern or dental problem? ____

I hereby confirm that the information provided above accurately reflects my current health condition as of today's date. In the event of any alterations in my health status or modifications to my medication, I will notify the dentist and staff during my next appointment.

First Name (Print) _______________________________ Last Name (Print) _____________________________________

Signature: ____ **Date:** ___________________________________

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other

Thank you for taking the time to fill out our health questionnaire.