MEDICAL AND DENTAL HISTORY

Patient Name: Birth Date: Date Created:

WE TAKE YOUR ORAL HEALTH VERY SERIOUSLY. PLEASE TAKE TIME TO THOUROUGHLY COMPLETE THIS HEALTH HISTORY FORM.
ANY HEALTH PROBLEMS THAT YOU HAVE OR MEDICATIONS THAT YOU TAKE MAY AFFECT YOUR DENTAL TREATMENT.

DATE OF LAST DENTAL VISIT: REASON FOR TODAY'S VISIT:

FORMER DENTIST: DATE OF LAST DENTAL X-RAYS:

DENTAL HISTORY

PLEASE CHECK IF YOU HAVE:

Bad Breath	Yes No	Periodontal Treatement	Yes No
Sensitivity to temperature or sweets	Yes No	Headaches	Yes No
Swollen gums, tender or bleeding	Yes No	Dry Mouth	Yes No
Bite splint/Night guard	Yes No	Food collecting between teeth	Yes No
Chewing Tobacco	Yes No	Growths or sore areas in your mouth	Yes No
Pain in jaw (TMJ)	Yes No	Mouth Breathing	Yes No
Cigarette/ Pipe Smoking	Yes No	Sensitivity to pressure	Yes No
Clenching or grinding teeth	Yes No	Orthodontic Treatment (past or present)	Yes No
Vapor Tobacco	Yes No		

HOW OFTEN DO YOU BRUSH?	Yes No	If yes	
HOW OFTEN DO YOU FLOSS?	Yes No	If yes	
ANY TROUBLE WITH PREVIOUS DENTAL CARE?	Yes No	If yes	
HAVE YOU EVER HAD AN ALLERGIC OR ADVERSE REACTIONS TO LOCAL OR GENERAL ANESTHETICS?	Yes No	If yes	

PHYSICIAN'S NAME: PHYSICIAN'S ADDRESS:

PHARMACY NAME: LOCATION:

LIST ANY MEDICATIONS THAT YOU ARE TAKING INCLUDING NON-PRESCRIPTIONS DRUGS SUCH AS HERBALS/VITAMINS:

WOMEN

Women: Are you...

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

Estimated Delivery Date:

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician regarding alternative forms for birth control.

MEDICAL HEALTH

DO YOU CURRENTLY HAVE, OR HAVE EVER HAD ANY OF THE FOLLOWING?

Arthritis/ Rheumatism	Yes No	Anemia	Yes No	Easily Winded	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joint	Yes No	Diabetes (Type:)	Yes No	Asthma (Trigger:)	Yes No	Epilepsy or Seizures	Yes No
Artificial Heart Valve	Yes No	Hypoglycemia	Yes No	Lung Disease	Yes No	Convulsions	Yes No
Pacemaker	Yes No	Hepatitis (Type:)	Yes No	Tuberculosis	Yes No	Kidney Disease	Yes No
Heart Murmur	Yes No	Liver Disease	Yes No	Cough- persistant/ bloody	Yes No	Dialysis	Yes No
Heart Attack	Yes No	Chemical Dependency	Yes No	Sinus Problems	Yes No	Excessive Thirst	Yes No
Angina/ Chest Pains	Yes No	Frequent Headaches	Yes No	Hay Fever	Yes No	Ulcers/ Stomach Problems	Yes No
Congenital Heart Disorder	Yes No	Stroke	Yes No	Anaphylaxis	Yes No	Frequent Diarrhea	Yes No
Mitral Valve Prolapse	Yes No	Osteoporosis	Yes No	Hives or Rash	Yes No	Thyroid Problems	Yes No
High Blood Pressure	Yes No	Osteopenia	Yes No	Cancer (Type:)	Yes No	Cold Sores/ Fever Blisters	Yes No
Low Blood Pressure	Yes No	Unexplained Weight Loss	Yes No	Chemotherapy	Yes No	Tonsilitis	Yes No
High Cholesterol	Yes No	Jaundice	Yes No	Radiation Treatment	Yes No	Glaucoma	Yes No
Blood Disease/ Clotting Disorder	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Alzheimer's disease	Yes No
Excessive Bleeding	Yes No	Emphysema	Yes No	HIV/ AIDS	Yes No		

Have you ever had any serious illness not listed? Yes No If yes

ARE YOU ALLERGIC TO THE FOLLOWING?

Aspirin	Yes No	Acrylic	Yes No	Sulfa	Yes No
Penicillin	Yes No	Metal	Yes No	Local anesthetics	Yes No
Codeine	Yes No	Latex	Yes No		

OTHER ALLERGIES? Yes No If yes

Have you ever had any serious illness or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking or have you taken Oral Bisphosphonates, e.g. FOSAMAX, ACTONEL, BONIVA? Yes No If yes

Have you taken antibiotics prior to dental procedures in the past? Yes No If yes

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:_____