MEDICAL & DENTAL HISTORY

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Do you have or have you had any of the following?
(*Please check any that apply*)

- ❑ Cancer or tumor
- ❑ Radiation or chemotherapy
- ❑ Serious illness or major surgery
- ❑ Heart disease or chest pain
- ❑ Stroke
- ❑ Artificial heart valve or heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Snoring or sleep apnea
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Blood transfusion
- ❑ Blood disorder (anemia, leukemia, etc.)
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Diabetes (last HbA1c______Date___________)
- ❑ Glaucoma
- ❑ Acid reflux (heartburn) or ulcers
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Dizziness or vertigo
- ❑ Emotional, neurologic, or psychiatric condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Do you consume more than one or two alcoholic beverages a day? ❑ yes ❑ no

Do you habitually use recreational drugs? ❑ yes ❑ no

Would you like to speak to the doctor privately about any problem? ❑ yes ❑ no

Have you ever been told to take antibiotics before your dental treatment? ❑ yes ❑ no
Why?_____________________________________

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Penicillin or other antibiotics
- ❑ Dental anesthetics
- ❑ Codeine or other narcotics
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Metals
- ❑ Other:________________________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Antibiotics
- ❑ Blood thinners (Coumadin,Plavix, etc.)
- ❑ High blood pressure medicine
- ❑ Antidepressants or sedatives
- ❑ Insulin, Metformin, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Vitamins/supplements
- ❑ Other (please list all medications and supplements):__________________________
____
____
____
____

Women:

- ❑ May be pregnant
  Expected delivery date:___________
- ❑ Taking hormones or contraceptives

Do you have any disease, condition, or problem not listed or anything about your health that we have not covered? If so, explain____

____

Does your drinking water contain fluoride? ❑ yes ❑ no

Have you ever been treated for gum disease? ❑ yes ❑ no

Do you clench or grind your teeth? ❑ yes ❑ no

Does your jaw click or pop? ❑ yes ❑ no

Are you happy with your smile? ❑ yes ❑ no

Are you interested in straightening your teeth? ❑ yes ❑ no

Would you like a whiter smile? ❑ yes ❑ no

Are you concerned with your breath? ❑ yes ❑ no

Are you interested in sedation dentistry? ❑ yes ❑ no

I CERTIFY THE INFORMATION ON THIS FORM IS COMPLETE AND ACCURATE

Patient Signature (Parental Guardian) ____ Date: ______________

Dentist Signature ____ Date: ______________

BP _______________ Date of last physical: ____________________

For Office Use Only

MEDICAL HISTORY UPDATE

Since your last visit: Has there been any changes in your health status? _____Yes _____No

Hospitalized? ____Yes ____ No Changes/Updates: ____

Current medications: ____

Date of last physical exam: ___________________ BP ________________

Since your last visit: Has there been any changes in your health status? _____Yes _____No

Hospitalized? ____Yes ____ No Changes/Updates: ____

Current medications: ____

Date of last physical exam: ___________________ BP _________________

Since your last visit: Has there been any changes in your health status? _____Yes _____No

Hospitalized? ____Yes ____ No Changes/Updates: ____

Current medications: ____

Date of last physical exam: ___________________ BP _________________