

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? ☐ Yes ☐ 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? ☐ Does it hurt to chew, bite or swallow? ☐ Do your gums bleed when you brush or floss your teeth? ☐ Have you ever had periodontal (gum) treatments like scaling and root planing? ☐ Do you have, or have you ever had, any sores or growths in your mouth? ☐ Do you clench or grind your teeth? ☐ Does your jaw click, pop or hurt? ☐ Do you have earaches or neck pains? ☐ Does dental treatment make you nervous? ☐ Have you ever experienced any of these sleep-related breathing disorders? ☐ ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep		Have you ever had a serious injury to your head or mouth? ☐ If yes, please describe what happened and when it happened: _____ _____ Have you ever had problems with dental treatment in the past? ☐ If yes, please describe what happened: _____ _____ Have you ever had a reaction to, or problem with, dental anesthesia? ☐ If yes, please describe what happened: _____ _____ Are you unhappy with your smile? ☐ If yes, why? Please mark all that apply: ☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth ☐ 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 blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐			
If yes, what medication are you taking? _____			
Are you taking any medication to treat osteoporosis or Paget's disease? ☐ ☐ ☐			
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 IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐			
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 hormonal replacements ? ☐ ☐ ☐			
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐			
Do you use vaping products ? ☐ ☐ ☐			
How many alcoholic beverages do you have per week? _____			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐			
If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally			
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ? ☐ ☐ ☐			
If yes, please list them here and include information about how much and how often you use each one. _____			
WOMEN ONLY: Are you:			
Taking birth control pills ? ☐ ☐ ☐			
Pregnant? If yes, number of weeks: _____ ☐ ☐ ☐			
Nursing? If yes, number of weeks: _____ ☐ ☐ ☐			

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	☐	☐	☐	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim),		
Barbiturates, sedatives or sleeping pills	☐	☐	☐	erythromycin-sulfisoxazole, sulfasalaz-ine (Azulfidine), erythromycin-		
Codeine or other narcotics	☐	☐	☐	sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs),		
Hay fever/seasonal allergies	☐	☐	☐	dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide		
Iodine	☐	☐	☐	(Microzide) and furosemide (Lasix)	☐	☐
Latex (rubber)	☐	☐	☐	Other	☐	☐
Local anesthetics	☐	☐	☐	Please describe any "Yes" answers and include information about your experience.		
Metals	☐	☐	☐			
Penicillin or other antibiotics	☐	☐	☐			

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?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	☐	☐	☐
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a heart valve replacement or heart surgery ?	☐	☐	☐
Have you had an organ or bone marrow/stem cell transplant ?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐

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	?				Yes	No	?
Heart (Cardiac) Health						Cancer					
Pacemaker/implanted defibrillator	☐	☐	☐	Type:	_____	☐	☐	☐	Digestive Health		
Artificial (prosthetic) heart valve	☐	☐	☐	Date of diagnosis:	_____	☐	☐	☐	Gastrointestinal disease	☐	☐
Previous infective endocarditis	☐	☐	☐	Chemotherapy:	_____	☐	☐	☐	G.E. reflux/persistent heartburn (GERD)	☐	☐
Congenital heart disease (CHD)	☐	☐	☐	Radiation treatment:	_____	☐	☐	☐	Stomach ulcers	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐	Blood (Circulatory) Health			Eye (Vision) Health			☐	☐
Repaired (completely) in last 6 months	☐	☐	☐	Anemia	☐	☐	☐	Glaucoma	☐	☐	
Repaired CHD with residual defects	☐	☐	☐	Blood transfusion	☐	☐	☐	Other			
Arteriosclerosis	☐	☐	☐	If yes, date:	_____	☐	☐	Arthritis	☐	☐	☐
Coronary artery disease	☐	☐	☐	Hemophilia	☐	☐	☐	Chronic pain	☐	☐	☐
Congestive heart failure	☐	☐	☐	High or low blood pressure	☐	☐	☐	Diabetes (type I or II)	☐	☐	☐
Damaged heart valves	☐	☐	☐	Brain (Neurological)/Mental Health			Eating disorder			☐	☐
Heart attack	☐	☐	☐	Anxiety	☐	☐	☐	Frequent infections	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐	Depression	☐	☐	☐	Type of infection:	_____		
Rheumatic heart disease	☐	☐	☐	Epilepsy	☐	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	☐
Stroke	☐	☐	☐	Mental health disorders	☐	☐	☐	Immune deficiency	☐	☐	☐
Breathing (Respiratory) Health						Neurological disorders			☐	☐	☐
Asthma (COPD)	☐	☐	☐				Post-traumatic stress disorder			☐	☐
Bronchitis	☐	☐	☐				Traumatic brain injury or concussion			☐	☐
Emphysema	☐	☐	☐				Autoimmune Disease				
Sinus trouble	☐	☐	☐				AIDS or HIV Infection			☐	☐
Tuberculosis	☐	☐	☐				Lupus			☐	☐

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

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: _____