

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? <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth? <input type="checkbox"/>
Does it hurt to chew, bite or swallow? <input type="checkbox"/>	If yes, please describe what happened and when it happened: _____
Do your gums bleed when you brush or floss your teeth? <input type="checkbox"/>	Have you ever had problems with dental treatment in the past? <input type="checkbox"/>
Have you ever had periodontal (gum) treatments like scaling and root planing? <input type="checkbox"/>	If yes, please describe what happened: _____
Do you have, or have you ever had, any sores or growths in your mouth? <input type="checkbox"/>	Have you ever had a reaction to, or problem with, dental anesthesia? <input type="checkbox"/>
Do you clench or grind your teeth? <input type="checkbox"/>	If yes, please describe what happened: _____
Does your jaw click, pop or hurt? <input type="checkbox"/>	Are you unhappy with your smile? <input type="checkbox"/>
Do you have earaches or neck pains? <input type="checkbox"/>	If yes, why? Please mark all that apply:
Does dental treatment make you nervous? <input type="checkbox"/>	<input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth
Have you ever experienced any of these sleep-related breathing disorders? <input type="checkbox"/>	<input type="checkbox"/> Other. Please describe: _____
<input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep	

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions.

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ Yes ☐ No ☐ ?

If yes, what medication are you taking? _____

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ Yes ☐ No ☐ ?

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? ☐ Yes ☐ No ☐ ?

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**? ☐ Yes ☐ No ☐ ?

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ Yes ☐ No ☐ ?

Do you use **vaping products**? ☐ Yes ☐ No ☐ ?

How many **alcoholic beverages** do you have per week? _____

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ Yes ☐ No ☐ ?

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**? ☐ Yes ☐ No ☐ ?

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**? ☐ Yes ☐ No ☐ ?

Pregnant? If yes, number of weeks: _____ ☐ Yes ☐ No ☐ ?

Nursing? If yes, number of weeks: _____ ☐ Yes ☐ No ☐ ?

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 antibiotics before having dental work done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a heart valve replacement or heart surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an organ or bone marrow/stem cell transplant ?	<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	?				Yes	No	?	
Heart (Cardiac) Health						Cancer						
Pacemaker/implanted defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____						Digestive Health		
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of diagnosis: _____						Gastrointestinal disease		
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy: _____						G.E. reflux/persistent heartburn (GERD).....		
Congenital heart disease (CHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment: _____						Stomach ulcers		
Unrepaired, cyanotic CHD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							Eye (Vision) Health		
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							Glaucoma.....		
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							Other		
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood (Circulatory) Health						Arthritis		
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....						Chronic pain		
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion.....						Diabetes (type I or II)		
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date: _____						Eating disorder		
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....						Frequent infections		
Heart murmur/rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure.....						Type of infection: _____		
Rheumatic heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							Hepatitis, jaundice or liver disease		
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain (Neurological)/Mental Health						Immune deficiency.....		
Breathing (Respiratory) Health				Anxiety.....						Kidney problems.....		
Asthma (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression.....						Malnutrition		
Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....						Osteoporosis.....		
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders						Rheumatoid arthritis		
Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....						Sexually transmitted infection (STI).....		
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-traumatic stress disorder						Thyroid problems		
				Traumatic brain injury or concussion.....								
				Autoimmune Disease								
				AIDS or HIV infection								
				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?	<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"/>	<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"/>	<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: _____