Medical History

Patient Name: _____

Name of Referring Dentist: _____ Last Visit:_____

Please state the reason for your visit today:

Are you now or have you been under the care of a physician during the past 12 months? : **Yes** ☐ **No** ☐

-If Yes, Please Explain: _____

-Name of Physician: _____ Phone Number: _____

Have you ever been hospitalized or had a major operation? **Yes** ☐ **No** ☐ _____

Have you ever had a serious head or neck injury? **Yes** ☐ **No** ☐ _____

Do you have any allergies or sensitivities? **Penicillin/Amoxicillin** ☐ **Sulfa Drugs** ☐ **Codeine** ☐ **Latex** ☐ **Local Anesthetics** ☐ **Metal** ☐ **Aspirin** ☐ **Acrylic** ☐ Other: _____

Are you taking any medications? **Yes** ☐ **No** _____

Please List All Medications:_____

Have you ever taken Fosamax, Boniva, or other bisphosphonates? **Yes** ☐ **No** ☐ _____

Have you had any adverse reactions to dental treatment? **Yes** ☐ **No** ☐_____

Do you require antibiotics prior to dental treatment? **Yes** ☐ **No** ☐_____

Women only*:* Are you taking oral contraceptives? **Yes** ☐ **No** ☐ _____

-Are you pregnant or trying to become pregnant? **Yes** ☐ **No** ☐_____

Do you have, or have you had any of the following: (please mark "Y" or "N")

Cardiac:	YES	NO	Bone and Joint Problems:	YES	NO
Shortness of Breath			Arthritis/Gout		
Heart Murmur			Joint Replacement		
Congenital Heart Disorder			Osteoporosis		
Artificial Heart Valve			Other Bone Metabolic Disorder		
Heart Attack/Stroke			Genitourinary:		
Pacemaker			Kidney Problems		
High Blood Pressure			Herpes		
Rheumatic Fever			Sexually Transmitted Disease		
Swollen Limbs/Feet			Excessive Urination		
High Cholesterol			Blood Disorders:		
Respiratory:			HIV/AIDS		
Asthma			Anemia		
Breathing Problems			Bruise/Bleed Easily		
Emphysema, Bronchitis			Blood Transfusion		
Tuberculosis			Hemophilia		
Sinusitis/Sinus Problems			Leukemia		
Endocrine:			Neurologic:		
Diabetes			Fainting spells, Seizures, Epilepsy		
Excessive Thirst			Frequent or severe headache		
Excessive Weight Gain or Loss			Neuritis/Neuralgia		
Thyroid Disease			Depression		
Gastrointestinal:			Psychiatric Care		
Ulcers			Growth or Tumor:		
Hepatitis			Cancer		
Liver Disease			Radiation/Chemotherapy		
Stomach/Intestinal Disease			Drug / Alcohol Dependency		
Weight Gain or Loss			Have you had any other condition not listed above?		
Acid Reflux (GERD)					

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Social History:	YES	NO
Do you smoke?		
If yes, how much?		
Quit? When?		
Do you drink alcohol?		
If yes, how much?		
Do you use recreational drugs?		
If yes, how much?		
Drug type?		
Family History:	**YES**	**NO**
Are you adopted?		
Have any family members ever been treated for the conditions listed below or any other medical problems?		
Diabetes		
High Blood Pressure		
Heart Problems		
Seizure		
Periodontal Disease (Tooth Loss)		
Other		
Dental History:	**YES**	**NO**
Do you experience dental anxiety?		
Do you gag easily?		
Does food catch between your teeth?		
Do you have difficulty chewing?		
Do you avoid brushing any part of your mouth because of pain?		
Do your gums bleed easily?		
Do you experience frequent sores in your mouth?		
Do you experience dry mouth?		
Do you experience tooth sensitivity?		
Does your jaw make noise, get tired, get stuck or hurt when you chew or open wide?		
Do you have jaw symptoms or headaches?		
Do you have a temporomandibular (jaw) disorder? (TMD, TMJ)		
Do you have pain in the face, cheeks or jaw?		

Do you feel twinges of pain when your teeth come into contact with:	YES	NO
Hot food or liquid?		
Cold food or liquid?		
Sours?		
Sweets?		
Do you experience frequent stress?		
Do you clench or grind your jaws?		
Do you have a nightguard?		
If yes, do you wear it regularly?		
Have you been diagnosed with sleep apnea?		
If yes, do you have a CPAP or other Device?		
Do you use it regularly?		
Have you ever been diagnosed with periodontal disease?		
Have you ever had a "deep cleaning"?		
Have you ever seen a periodontist?		
If yes, what treatment did you receive?		
How often do you brush?		
How often do you floss?		
How often do you receive professional cleanings?		

Patient Signature (Guardian if minor) ***Date:***

Dentist Initials: ***Date:***

Medical Form Annual Renewal:

Patient Initials/Date:	Doctor Initials/Date:
/	/
/	/
/	/

Doctor's Notes: