PATIENT MEDICAL / DENTAL HISTORY

Patient's Name **Date of Birth**

Your answers are for the office records only and are confidential. A thorough medical history is essential to a complete dental evaluation.

Are you under a Physician's care now?	☐Yes	☐No	Do you use tobacco?	☐Yes	☐No
Have you ever been hospitalized or had a major operation?	☐Yes	☐No	Do you use any controlled substance?	☐Yes	☐No
Have you ever had a serious head or neck injury?	☐Yes	☐No	Are you Pregnant or trying to get pregnant?	☐Yes	☐No
Do you take or have you taken Fosamax or Bisphosphonate?	☐Yes	☐No	Are you nursing?	☐Yes	☐No
Are you taking any blood thinner – Plavix, Heparin or Coumadin?	☐Yes	☐No	Are you taking oral contraceptives?	☐Yes	☐No

Are you allergic to any of the following? (Check all that apply)

☐Aspirin ☐Penicillin ☐Codeine ☐Sulfa ☐Amoxicillin ☐Nitrous Oxide ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other

If Yes, please explain: _____

Are you taking any medications, pills or drugs? ☐Yes ☐No

If yes, please list all medications: _____

_____

DENTAL HISTORY & CONCERN (Check all that apply)

Concerns	Y	N	Concerns	Y	N	Concerns	Y	N	Concerns	Y	N
Broken / Chipped Teeth	☐	☐	Bad Breath	☐	☐	Popping / Clicking	☐	☐	Mouth Sores	☐	☐
Lose Teeth	☐	☐	Sensitivity to Bite	☐	☐	Difficulty Opening / Closing	☐	☐	Red / Puffy Gums	☐	☐
Food Traps	☐	☐	Tooth Pain - Generalized	☐	☐	I Bite My Nails	☐	☐	I am a Tobacco User	☐	☐
Missing or Lost Filling	☐	☐	Stain / Discoloration	☐	☐	Cheek Biting	☐	☐	Gum Recession	☐	☐
Sensitivity to Hot / Cold	☐	☐	Clenching / Grinding	☐	☐	Sleep Apnea	☐	☐	Wisdom Teeth (3rd Molars)	☐	☐
Decay / Cavity	☐	☐	Sensitivity to Sweets	☐	☐	I Use CPAP	☐	☐	Avoid Chewing - L / R	☐	☐
Missing Teeth	☐	☐	Jaw Pain / Injury	☐	☐	Snoring	☐	☐	Crooked / Misaligned Teeth	☐	☐
Dental Phobia	☐	☐	Frequent Headaches	☐	☐	Bleeding / Swollen Gums	☐	☐	I wear a Retainer	☐	☐
Difficulty Chewing	☐	☐	Pain in Temples	☐	☐	Dry Mouth	☐	☐	I wear a Nightguard	☐	☐

MEDICAL HISTORY (Check all that apply)

Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N
AIDS/HIV Positive	☐	☐	Dizziness	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Alzheimer's Disease	☐	☐	Drug Addiction	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Angina	☐	☐	Epilepsy or Seizures	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Anaphylaxis	☐	☐	Excessive Bleeding	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Arthritis/Gout	☐	☐	Excessive Thirst	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Artificial Joints	☐	☐	Fainting Spells/Dizziness	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐
Asthma	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Breathing Problem	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Easy bruising	☐	☐	Hay fever	☐	☐	Mitral Valve Prolapses	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Heart Attack/ Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Chest Pain/Discomfort	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
Congenital Heart Disease	☐	☐	Hemophilia	☐	☐	Radiation Treatments	☐	☐	Yellow Jaundice	☐	☐
Convulsions	☐	☐	Hepatitis B or C	☐	☐	Rheumatic Fever	☐	☐			
Cortisone Medicine	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐			
Diabetes	☐	☐	Herpes	☐	☐	Renal Dialysis	☐	☐			

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 my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____

Patient's (or legal guardian) Signature Name of the Patient Date