

# 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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"/> Does it hurt to chew, bite or swallow? ..... <input type="checkbox"/> Do your gums bleed when you brush or floss your teeth? ..... <input type="checkbox"/> Have you ever had periodontal (gum) treatments like scaling and root planing? ..... <input type="checkbox"/> Do you have, or have you ever had, any sores or growths in your mouth? ..... <input type="checkbox"/> Do you clench or grind your teeth? ..... <input type="checkbox"/> Does your jaw click, pop or hurt? ..... <input type="checkbox"/> Do you have earaches or neck pains? ..... <input type="checkbox"/> Does dental treatment make you nervous? ..... <input type="checkbox"/> Have you ever experienced any of these sleep-related breathing disorders? ..... <input type="checkbox"/> <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep	Have you ever had a serious injury to your head or mouth? ..... <input type="checkbox"/> If yes, please describe what happened and when it happened: _____ _____ Have you ever had problems with dental treatment in the past? ..... <input type="checkbox"/> If yes, please describe what happened: _____ _____ Have you ever had a reaction to, or problem with, dental anesthesia? ..... <input type="checkbox"/> If yes, please describe what happened: _____ _____ Are you unhappy with your smile? ..... <input type="checkbox"/> If yes, why? Please mark all that apply: <input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth <input type="checkbox"/> Other. Please describe: _____		
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions. <span style="float: right;">Yes No ?</span>			
Are you taking any <b>blood thinners</b> (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what medication are you taking? _____			
Are you taking any medication to treat <b>osteoporosis</b> or Paget's disease? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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 <b>IV medication</b> to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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 <b>hormonal replacements</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use any form of <b>tobacco or nicotine products</b> (cigarettes, cigars, snuff, chew, bidis)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use <b>vaping products</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
How many <b>alcoholic beverages</b> do you have per week? _____			
Do you use <b>controlled substances</b> (drugs), including marijuana, for either medicinal or recreational reasons? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, for what reason(s)? _____			
Do you take any other <b>prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, please list them here and include information about how much and how often you use each one. _____			
Do you use <b>GLP-1 Glucagon-Like Peptide-1 medication</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>WOMEN ONLY:</b> Are you:			
Taking <b>birth control pills</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>Pregnant?</b> If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>Nursing?</b> If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

**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),	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs),	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Microzide) and furosemide (Lasix)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please describe any "Yes" answers and include information about your experience.			
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.**

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

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"/>	<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"/>	<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"/>	<input type="checkbox"/>	<b>Over the past two weeks</b> , have you felt connected to the world around you?	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>		<input type="checkbox"/>	<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: \_\_\_\_\_