**Osage Dental Medical History Form**

**Patient Information**

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_  **Age:** \_\_\_\_\_\_  **Sex:** ☐ Male ☐ Female ☐ Other

**Social Security #** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **State:** \_\_\_\_\_\_  **Zip:** \_\_\_\_\_\_\_\_\_\_  
**Phone:** (\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_  **Are you okay with text messaging?** ☐ yes ☐ No **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Emergency Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Emergency Contact Phone:** (\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_  
**Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician Information**

**Physician Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Phone:** (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_  
**Last Medical Exam:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**Medical History**

Please check all that apply and provide additional details where indicated.

**Cardiovascular**

☐ **Heart Disease**

* Type of Heart Disease (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date or Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How was it diagnosed? (e.g., EKG, Echo, Stress Test): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medications you're currently taking for heart disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you take blood thinners? ☐ Yes ☐ No  
    If yes, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Last INR Reading: \_\_\_\_\_\_\_\_ (Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_)

☐ High Blood Pressure  ☐ Low Blood Pressure  ☐ Heart Attack (Date: \_\_\_\_\_\_\_\_\_\_\_\_)  
☐ Heart Murmur  ☐ Rheumatic Fever  ☐ Stroke  
☐ Angina (Chest Pain)  ☐ Pacemaker  ☐ Congenital Heart Disease  
☐ Heart Surgery (Type/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Respiratory**

☐ Asthma  ☐ COPD  ☐ Sleep Apnea  ☐ Tuberculosis (TB)  ☐ Shortness of Breath

**Endocrine / Hormonal**

☐ **Diabetes** (Check one): ☐ Type 1  ☐ Type 2  ☐ Gestational

* Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Last A1C Reading: \_\_\_\_\_\_\_\_ % (Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_)
* Most Recent Blood Sugar Reading: \_\_\_\_\_\_\_\_ mg/dL (Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_)

☐ Thyroid Disease  ☐ Hormone Therapy

**Neurological**

☐ Epilepsy / Seizures  ☐ Fainting Spells  ☐ Migraines / Headaches  
☐ Anxiety / Panic Attacks  ☐ Depression  ☐ Alzheimer’s / Dementia

**Gastrointestinal / Liver**

☐ Acid Reflux / GERD  ☐ Liver Disease / Hepatitis  ☐ Jaundice

**Blood Disorders**

☐ Anemia  ☐ Excessive Bleeding  ☐ Blood Thinners (e.g., Coumadin, Xarelto)  
☐ Bruise Easily  ☐ Blood Transfusion (Date: \_\_\_\_\_\_\_\_\_\_\_)

**Infectious Diseases**

☐ HIV / AIDS  ☐ Hepatitis A / B / C  ☐ COVID-19 (Date: \_\_\_\_\_\_\_\_)  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_

**Autoimmune / Musculoskeletal**

☐ **Autoimmune Condition**

* Type of Autoimmune Condition (e.g., Lupus, RA, MS): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date Diagnosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medications or Treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Has this condition impacted your ability to perform daily activities (work, exercise, etc.)?  
    ☐ Yes  ☐ No  
    If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Arthritis (Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  ☐ Joint Replacement (Date/Joint: \_\_\_\_\_\_\_\_\_\_\_)  
☐ Osteoporosis  ☐ Steroid Treatment

**Cancer History**

☐ **History of Cancer**

* Type of Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date Diagnosed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_
* Are you currently in remission? ☐ Yes  ☐ No  ☐ Unsure
* Are you undergoing any current therapy?  
   ☐ Chemotherapy  ☐ Radiation  ☐ Immunotherapy  ☐ Hormone Therapy  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_
* If treatment has ended, when did it end? \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**Lifestyle Factors**

☐ Tobacco Use (Type: \_\_\_\_\_\_\_\_\_\_\_ Amount/Frequency: \_\_\_\_\_\_\_\_\_\_\_)  
☐ Alcohol Use  ☐ Drug Use  
☐ Pregnancy (Due Date: \_\_\_\_\_\_\_\_\_\_\_)  ☐ Nursing  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

Please list all current medications, including prescriptions, over-the-counter drugs, vitamins, and supplements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Medication Name** | **Dosage** | **Reason** |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

☐ I have a printed medication list I would like to provide.

**Dry Mouth Screening (Xerostomia):**

* Have you noticed **dry mouth or reduced saliva** since starting any medications?  
    ☐ Yes  ☐ No  If yes, which medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you ever **wake up at night needing to drink water** due to dry mouth?  
    ☐ Yes  ☐ No
* Do you ever feel like you **can’t spit** or that your mouth feels **sticky or overly dry**?  
    ☐ Yes  ☐ No

**Allergies**

☐ Latex  ☐ Penicillin / Antibiotics  ☐ Aspirin  ☐ Local Anesthetics  
☐ Sulfa Drugs  ☐ Codeine / Narcotics  ☐ Food Allergies: \_\_\_\_\_\_\_\_\_\_\_  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe reactions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

**Date of Last Dental Visit:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_  
**Name of Previous Dentist:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Reason for Today’s Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Tooth Pain or Sensitivity  ☐ Bleeding Gums  ☐ Gum Disease / Periodontal Treatment  
☐ Loose Teeth  ☐ Grinding / Clenching  ☐ Jaw Pain or TMJ Issues  
☐ Dry Mouth  ☐ Sores or Lesions in Mouth  ☐ Bad Breath  
☐ Fear or Anxiety about Dental Treatment  
☐ Dentures / Partials  ☐ Implants / Bridges / Crowns  ☐ Orthodontic Treatment (Braces)

**Authorization & Acknowledgement**

**Consent for Treatment:**  
I certify that the above information is accurate and complete to the best of my knowledge. I understand that providing incorrect or incomplete information may be dangerous to my health. I authorize **Osage Dental** and its staff to perform necessary dental services I may need.

**HIPAA Acknowledgment:**  
I acknowledge that I have received or been offered a copy of **Osage Dental's Notice of Privacy Practices**.

**Financial Responsibility:**  
I understand that I am financially responsible for all charges whether or not covered by insurance.

**Signature of Patient (or Parent/Guardian if minor):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_