

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? ☐		Have you ever had a serious injury to your head or mouth? ☐			
Does it hurt to chew, bite or swallow? ☐		If yes, please describe what happened and when it happened: _____			
Do your gums bleed when you brush or floss your teeth? ☐		Have you ever had problems with dental treatment in the past? ☐			
Have you ever had periodontal (gum) treatments like scaling and root planing? ☐		If yes, please describe what happened: _____			
Do you have, or have you ever had, any sores or growths in your mouth? ☐		Have you ever had a reaction to, or problem with, dental anesthesia? ☐			
Do you clench or grind your teeth? ☐		If yes, please describe what happened: _____			
Does your jaw click, pop or hurt? ☐		Are you unhappy with your smile? ☐			
Do you have earaches or neck pains? ☐		If yes, why? Please mark all that apply:			
Does dental treatment make you nervous? ☐		☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth			
Have you ever experienced any of these sleep-related breathing disorders? ☐		☐ Other. Please describe: _____			
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep					
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES					
Please use an "X" to mark your answers to the following questions. Yes No ?					
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐					
If yes, what medication are you taking? _____					
Are you taking any medication to treat osteoporosis or Paget's disease? ☐ ☐ ☐					
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? ☐ ☐ ☐					
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 ? ☐ ☐ ☐					
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐					
Do you use vaping products ? ☐ ☐ ☐					
How many alcoholic beverages do you have per week? _____					
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐					
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 ? ☐ ☐ ☐					
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 ? ☐ ☐ ☐					
Pregnant? If yes, number of weeks: _____ ☐ ☐ ☐					
Nursing? If yes, number of weeks: _____ ☐ ☐ ☐					

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		☐ ☐ ☐	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)..... ☐ ☐ ☐ Other ☐ ☐ ☐ Please describe any "Yes" answers and include information about your experience. _____
Barbiturates, sedatives or sleeping pills		☐ ☐ ☐	
Codeine or other narcotics		☐ ☐ ☐	
Hay fever/seasonal allergies		☐ ☐ ☐	
Iodine		☐ ☐ ☐	
Latex (rubber)		☐ ☐ ☐	
Local anesthetics.....		☐ ☐ ☐	
Metals		☐ ☐ ☐	
Penicillin or other antibiotics.....		☐ ☐ ☐	
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? ☐ ☐ ☐			
Are you currently being seen or treated by a physician? ☐ ☐ ☐			
Has a physician or previous dentist recommended that you take antibiotics before having dental work done? ☐ ☐ ☐			
Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ ☐ ☐			
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)? ☐ ☐ ☐			
Have you had a heart valve replacement or heart surgery ? ☐ ☐ ☐			
Have you had an organ or bone marrow/stem cell transplant ? ☐ ☐ ☐			
Have you traveled internationally within the last 30 days ☐ ☐ ☐			
Have you had a fever (100.4°F or above) in the last 72 hours? ☐ ☐ ☐			
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 ☐ ☐ ☐	Digestive Health
Pacemaker/implanted defibrillator ☐ ☐ ☐		Type: _____	Gastrointestinal disease ☐ ☐ ☐
Artificial (prosthetic) heart valve ☐ ☐ ☐		Date of diagnosis: _____	G.E. reflux/persistent heartburn (GERD)..... ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐		Chemotherapy: _____	Stomach ulcers..... ☐ ☐ ☐
Congenital heart disease (CHD) ☐ ☐ ☐		Radiation treatment: _____	Eye (Vision) Health
Unrepaired, cyanotic CHD..... ☐ ☐ ☐		Blood (Circulatory) Health	Glaucoma..... ☐ ☐ ☐
Repaired (completely) in last 6 months ☐ ☐ ☐		Anemia..... ☐ ☐ ☐	Other
Repaired CHD with residual defects ☐ ☐ ☐		Blood transfusion..... ☐ ☐ ☐	Arthritis..... ☐ ☐ ☐
Arteriosclerosis..... ☐ ☐ ☐		If yes, date: _____	Chronic pain ☐ ☐ ☐
Coronary artery disease..... ☐ ☐ ☐		Hemophilia..... ☐ ☐ ☐	Diabetes (type I or II) ☐ ☐ ☐
Congestive heart failure..... ☐ ☐ ☐		High or low blood pressure..... ☐ ☐ ☐	Eating disorder ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐		Brain (Neurological)/Mental Health	Frequent infections..... ☐ ☐ ☐
Heart attack..... ☐ ☐ ☐		Anxiety..... ☐ ☐ ☐	Type of infection: _____
Heart murmur/rhythm disorder ☐ ☐ ☐		Depression..... ☐ ☐ ☐	Hepatitis, jaundice or liver disease ☐ ☐ ☐
Rheumatic heart disease..... ☐ ☐ ☐		Epilepsy..... ☐ ☐ ☐	Immune deficiency..... ☐ ☐ ☐
Stroke..... ☐ ☐ ☐		Mental health disorders ☐ ☐ ☐	Kidney problems..... ☐ ☐ ☐
Breathing (Respiratory) Health		Neurological disorders..... ☐ ☐ ☐	Malnutrition ☐ ☐ ☐
Asthma (COPD) ☐ ☐ ☐		Post-traumatic stress disorder ☐ ☐ ☐	Osteoporosis..... ☐ ☐ ☐
Bronchitis..... ☐ ☐ ☐		Traumatic brain injury or concussion..... ☐ ☐ ☐	Rheumatoid arthritis ☐ ☐ ☐
Emphysema..... ☐ ☐ ☐		Autoimmune Disease	Sexually transmitted infection (STI)..... ☐ ☐ ☐
Sinus trouble..... ☐ ☐ ☐		AIDS or HIV Infection ☐ ☐ ☐	Thyroid problems..... ☐ ☐ ☐
Tuberculosis..... ☐ ☐ ☐		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 ?
had pain or tightness in the chest?..... ☐ ☐ ☐		found it hard to catch your breath? ☐ ☐ ☐	experienced vomiting, diarrhea, chills, night sweats or bleeding?..... ☐ ☐ ☐ had migraines or severe headaches? ☐ ☐ ☐
coughed up blood or had a cough that lasted longer than 3 weeks? ☐ ☐ ☐		had a high fever (greater than 101.5°F) for no reason?..... ☐ ☐ ☐	
been exposed to anyone with tuberculosis?..... ☐ ☐ ☐		noticed a change in your vision? ☐ ☐ ☐	
had a rapid or irregular heart beat? ☐ ☐ ☐		fainted for no reason?..... ☐ ☐ ☐	
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: _____	