

Medical and Dental History

To ensure your well being while undergoing treatment in our office, please answer the following questions with a YES or NO response and provide details for all YES responses. All information will be considered confidential and for our records only.

Have you ever had any of the following:

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Liver Problem	<input type="checkbox"/>	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis A B C
<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/> Organ Transplant
<input type="checkbox"/>	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/> Cancer or Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems (males)	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/> Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/>	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/> Hemophilia	<input type="checkbox"/>	<input type="checkbox"/> Emphysema
<input type="checkbox"/>	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Fainting
<input type="checkbox"/>	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> Rheumatism	<input type="checkbox"/>	<input type="checkbox"/> Headaches
<input type="checkbox"/>	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/> Smoking / Vaping
<input type="checkbox"/>	<input type="checkbox"/> Pacemaker	<input type="checkbox"/>	<input type="checkbox"/> Cortisone / Steroid Therapy	<input type="checkbox"/>	<input type="checkbox"/> Marijuana
<input type="checkbox"/>	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/> Herpes	<input type="checkbox"/>	<input type="checkbox"/> Tumors or Growth
<input type="checkbox"/>	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/>	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/> Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/> Latex Allergy
<input type="checkbox"/>	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/> AIDS / HIV
<input type="checkbox"/>	<input type="checkbox"/> Chemical/Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/> Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/> Lupus
<input type="checkbox"/>	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination		

Any other illness not listed above ? ☐ Yes ☐ No If Yes, please explain:_____

Comments: _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal

☐ Other drug allergies _____

Please list *ALL* medications you currently take or have taken in the last year. Please include vitamins.

Medication	Dosage	Reason	When Started
1.			
2.			
3.			
4.			
5.			

Physician's Name

Physician's Address

Physician's Phone

Physician's Fax

Last Visit Date and Reason

Please answer the following:

Yes No

- ☐ ☐ 1. Have you been hospitalized in the last 10 years? Reason _____
- ☐ ☐ 2. Have you had any serious illnesses or operations? Describe _____
- ☐ ☐ 3. Have you been treated previously, or are currently being treated, for osteoporosis with Antiresorptive or Bisphosphonate drugs (i.e., Prolia, Fosamax, Reclast, Aclasta, Boniva, Actonel, Zometa, Aredia, or other Antiresorptive or Bisphosphonate drugs or IV Zometa or Aredia)?
If yes, explain _____
- ☐ ☐ 4. Have you taken cortisone or steroids in the last 6 months? Reason _____
- ☐ ☐ 5. Have you ever been told by your physician that you need antibiotics for dental appointments? _____
- ☐ ☐ 6. Are you taking hormone replacement therapy? If so, list _____
- ☐ ☐ 7. Have you ever had any reaction to anesthesia? If so, list _____
- ☐ ☐ 8. Have you ever taken Fen-Phen or Redux? If so, when and for how long? _____
- ☐ ☐ 9. Do you currently smoke or are a past smoker? If so, describe _____
- ☐ ☐ 10. Do you need to premedicate for dental visits? _____

Women: Are you:

Pregnant/Trying to get pregnant? ☐ Yes ☐ No / Taking birth control pills? ☐ Yes ☐ No / Nursing? ☐ Yes ☐ No

Dental History

Reason for today's visit _____

Date of last Full Mouth X-Rays _____

Check if you have had the following:

- | | | | |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Dental Implants |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Shifting of teeth | <input type="checkbox"/> Receding gums | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Sensitivity to hot/cold | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Gum boils/abscess |
| <input type="checkbox"/> Bite Change | <input type="checkbox"/> Pain when chewing | <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Trouble chewing |

What concerns you about your mouth? _____

Are you happy with your smile? If not, explain _____

How do you feel about having a partial denture or denture (false teeth)? _____

Additional Comments: _____

Signature of Patient or Legal Guardian _____ **Date** _____

Doctor Signature _____ **Date** _____