

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. _____				
Do you use GLP-1 Glucagon-Like Peptide-1 medication ?				☐ ☐ ☐
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), dapson, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix).
Barbiturates, sedatives or sleeping pills	☐ ☐ ☐		
Codeine or other narcotics	☐ ☐ ☐		
Hay fever/seasonal allergies	☐ ☐ ☐		
Iodine	☐ ☐ ☐		
Latex (rubber)	☐ ☐ ☐		Other
Local anesthetics	☐ ☐ ☐		
Metals	☐ ☐ ☐		Please describe any "Yes" answers and include information about your experience.
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 ?
Heart (Cardiac) Health			Digestive Health
Pacemaker/implanted defibrillator	☐ ☐ ☐		Gastrointestinal disease
Artificial (prosthetic) heart valve	☐ ☐ ☐		G.E. reflux/persistent heartburn (GERD).
Previous infective endocarditis	☐ ☐ ☐		Stomach ulcers
Congenital heart disease (CHD)	☐ ☐ ☐		Eye (Vision) Health
Unrepaired, cyanotic CHD	☐ ☐ ☐		Glaucoma
Repaired (completely) in last 6 months	☐ ☐ ☐		
Repaired CHD with residual defects	☐ ☐ ☐		Other
Arteriosclerosis	☐ ☐ ☐		Arthritis
Coronary artery disease	☐ ☐ ☐		Chronic pain
Congestive heart failure	☐ ☐ ☐		Diabetes (type I or II)
Damaged heart valves	☐ ☐ ☐		Eating disorder
Heart attack	☐ ☐ ☐		Frequent infections
Heart murmur/rhythm disorder	☐ ☐ ☐		Type of infection:
Rheumatic heart disease	☐ ☐ ☐		Hepatitis, jaundice or liver disease
Stroke	☐ ☐ ☐		Immune deficiency
Breathing (Respiratory) Health			Kidney problems
Asthma (COPD)	☐ ☐ ☐		Malnutrition
Bronchitis	☐ ☐ ☐		Osteoporosis
Emphysema	☐ ☐ ☐		Rheumatoid arthritis
Sinus trouble	☐ ☐ ☐		Sexually transmitted infection (STI)
Tuberculosis	☐ ☐ ☐		Thyroid problems
Cancer	☐ ☐ ☐		
Type:			
Date of diagnosis:			
Chemotherapy:			
Radiation treatment:			
Blood (Circulatory) Health			
Anemia	☐ ☐ ☐		
Blood transfusion	☐ ☐ ☐		
If yes, date:			
Hemophilia	☐ ☐ ☐		
High or low blood pressure	☐ ☐ ☐		
Brain (Neurological)/Mental Health			
Anxiety	☐ ☐ ☐		
Depression	☐ ☐ ☐		
Epilepsy	☐ ☐ ☐		
Mental health disorders	☐ ☐ ☐		
Neurological disorders	☐ ☐ ☐		
Post-traumatic stress disorder	☐ ☐ ☐		
Traumatic brain injury or concussion	☐ ☐ ☐		
Autoimmune Disease			
AIDS or HIV Infection	☐ ☐ ☐		
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 ?	Yes No ?
had pain or tightness in the chest?	☐ ☐ ☐	found it hard to catch your breath?	experienced vomiting, diarrhea, chills, night sweats or bleeding?
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?	had migraines or severe headaches?
been exposed to anyone with tuberculosis?	☐ ☐ ☐	noticed a change in your vision?	Over the past two weeks, have you felt connected to the world around you?
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:	