PATIENT DENTAL & MEDICAL HEALTH HISTORY

Today's Date: _____

Patient name (first and last): _____ ***DOB***:_____

Current Address: _____ ***City***:_____ ***State***:_____ ***Zip***:_____

Home Phone:_____ ***Work Phone***:_____ ***Cell Phone***:_____

Email: _____ ***Preferred Methods of Contact*: CALL / EMAIL / TEXT**

Emergency Contact (Name and Number) _____

Are you under the care of a physician at the present time? **YES or NO**

If so, what is the condition being treated? _____

***Primary Care Physician & Contact Information*:** _____

Preferred Pharmacy:_____ ***Pharmacy Phone Number***:_____

Do you have dental insurance coverage*? YES or NO** ***Insurance Provider:_____

***Insurance Group # or member ID # if provided*:** _____

Dental Health:

Yes	No	
☐	☐	Are you having any pain or discomfort at this time?
☐	☐	Do your gums bleed while brushing and flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Have you ever experienced any of the following problems with your jaw? **(Circle all that apply): clicking / pain / difficulty in opening and closing / difficulty in chewing**
☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth? If yes, when? _____
☐	☐	Have you ever had any orthodontic treatment? If so, do you wear a retainer? _____
☐	☐	Have you ever had any type of trauma to your mouth, jaw, or face? If yes, describe:_____
☐	☐	Do you wear dentures or partials? If so, date of placement: _____
☐	☐	Do you have any concerns about bad breath odor?
☐	☐	Are you pleased with the appearance and color of your teeth when you smile?

Medical Health:

Are you **allergic** or have you reacted adversely to any of the following (check all that apply):

_____Aspirin
_____Codeine
_____Nitrous Oxide
_____Penicillin
_____Erythromycin
_____Other antibiotics _____
_____Latex, Metals, Plastic
__Ibuprofen
__Sulfa Drugs, Sulfites, Sulfides
___Acetaminophen/Tylenol
___Barbiturates
___ Tetracycline
___ Local Anesthesia
____ Other

Yes	No	
☐	☐	Have you been hospitalized during the past two years?
☐	☐	Have you been asked by your medical doctor to premedicate before any dental treatment? **If yes, what premedication was prescribed?** _____
☐	☐	**(Circle all that apply)** Do you smoke, chew, or vape nicotine/tobacco? If yes, how often?_____
☐	☐	**(Circle all that apply)** Do you smoke, ingest, or vape marijuana? If yes, how often?_____
☐	☐	Do you drink alcohol? If yes, how often and in what quantity? _____

Check or Circle any of the following that you have had or have at the present:

___Osteoporosis
___Heart disease or heart attack
___Abnormal blood pressure
___Heart murmur/mitral valve prolapse
___Rheumatic fever
___Heart pacemaker
___Heart surgery
___Stroke
___Kidney disease
___History of drug addiction /alcoholism
___Arthritis
___ Congenital heart lesions
___Bleeding disorders
___ Sinus issues
___ Infectious mononucleosis (mono)
___Dementia/ Memory Loss

___ Bisphosphonate therapy (e.g. Boniva)
___Asthma
___Diabetes
___Thyroid issues
___ Hepatitis A, B, C
___ Hemophilia
___ Epilepsy or seizures
___ Psychiatric treatment
___ Artificial joints
___ Implants
___ AIDS or HIV+
___ Sickle Cell Disease
___ Tuberculosis or lung disease
___ Hay fever
___Cancer/chemotherapy/radiation
___Jaundice

___ Shingles
___ Glaucoma
___ Headaches
___ Fainting
___ Hard of Hearing
___ Anaphylaxis
___ Allergies
___ Blood Transfusion
___ Herpes
___Ulcers
___ Liver Disease
___Anemia
___ Radiation Treatment
___ Tumor or Malignancy
___Sexually Transmitted Disease

OTHER: _____

Major surgeries (type and year): _____

_____

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies, and supplements.

Name of Medication	Prescribed Dosage

Are you pregnant now? **YES** or **NO** **Are you nursing?** **YES** or **NO**

Do you have a history of miscarriages? **YES** or **NO**

Do you take any hormones or birth control pills? _____

Authorization: I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Patient Signature: _____ **Date:** _____

Guardian Signature: _____

Doctor Signature: _____ **Date:** _____