



Patient Name: _____ Patient Date of Birth: _____

PATIENT MEDICAL/DENTAL HISTORY

Has there been any change in your general health within the past year Yes No

If yes, please explain: _____

Have you been hospitalized within the past five years Yes No

If yes, please explain: _____

Are you required to take antibiotics before any dental treatment Yes No

When was your last complete dental check-up and cleaning: _____ ?

Have you ever been treated for periodontal disease (gum disease) (pyorrhea) (trench mouth)

Name, Address, Phone Number of your general dentist:

Name, Address, Phone Number of your medical physician:

Mouth/Teeth:

Do you have or have you had:

Burning tongue/lip YES or NO **Temporomandibular joint problems (TMJ)** YES or NO

Bleeding, sore gums YES or NO **Loose teeth** YES or NO

Unpleasant taste YES or NO **Clenching/grinding** YES or NO

Swollen lumps or infections YES or NO **Do you wear a Night Guard?** YES or NO

Clicking or popping jaws YES or NO **Orthodontic treatment:** YES or NO

Difficulty opening jaw YES or NO Age: _____ How many years? _____

Food Impaction YES or NO **Any change in bite. Please explain** YES or NO

Sensitive teeth YES or NO _____

If YES, check those that apply: hot cold sweets pressure



Medications:

Are you taking any of the following (Please provide us a list of medications you are currently taking)

- Antibiotics, sulfa drugs
- Anticoagulants; (blood thinners, Coumadin, Aspirin, etc)
- Medicine for high blood pressure
- Steroids
- Antihistamines, Aspirin
- Medication to treat diabetes
- Nitroglycerine
- Phen-Fen: _____ How long ago was your last heart exam: _____

Please list all the medications you are currently taking. Include the dosage, how often, and if applicable, the reason you are taking it.

Are you required to take antibiotics before any dental treatment due to a heart murmur or mitral valve prolapse?

- YES NO

Please let us know of any allergies, medical problems, etc that has not been listed on these forms immediately! Thank you! 😊

Allergies: _____

Are you allergic to Latex ? YES NO

Are you allergic to a specific antibiotic or anesthetic before any treatment? YES NO

To the best of my knowledge the information above is current and accurate. I have listed all medications I am currently taking and listed all products that I am allergic to. I understand that it is my responsibility to notify the office of any changes in intake or allergies.

Patient's Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____



I. Circle Appropriate Answer (leave blank if you do not understand the question):

- 1. Yes No Are you in good health?
- 2. Yes No Has there been a change in your health within the last year? _____
- 3. Yes No Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
- 4. Yes No Are you being treated by a physician now? For what? _____
- 5. Yes No Have you had problems with your prior dental treatment?
- 6. Yes No Are you in pain now? _____

II. Have You Experienced:

- | | |
|---|-----------------------------------|
| 7. Yes No Chest Pain (angina)? | 18. Yes No Dizziness? |
| 8. Yes No Swollen ankles? | 19. Yes No Ringing in ears? |
| 9. Yes No Shortness of breath? | 20. Yes No Headaches? |
| 10. Yes No Recent weight loss, fever, night sweats? | 21. Yes No Fainting spells? |
| 11. Yes No Persistent cough, coughing up blood? | 22. Yes No Blurred vision? |
| 12. Yes No Bleeding Problems, bruising easily? | 23. Yes No Seizures? |
| 13. Yes No Sinus Problems? | 24. Yes No Excessive thirst? |
| 14. Yes No Difficulty Swallowing? | 25. Yes No Frequent urination? |
| 15. Yes No Diarrhea, constipation, blood in stools? | 26. Yes No Dry mouth? |
| 16. Yes No Frequent vomiting, nausea? | 27. Yes No Jaundice? |
| 17. Yes No Difficulty Urinating? | 28. Yes No Joint pain, stiffness? |

III. Do You Have or Have You Had:

- | | |
|--|--|
| 29. Yes No Heart Disease? | 40. Yes No AIDS? |
| 30. Yes No Heart attack, heart defects? | 41. Yes No Tumors, cancer? |
| 31. Yes No Heart murmurs? | 42. Yes No Arthritis, rheumatism? |
| 32. Yes No Rheumatic fever? | 43. Yes No Eye Disease? |
| 33. Yes No Stroke, hardening of arteries? | 44. Yes No Skin disease? |
| 34. Yes No High blood pressure? | 45. Yes No Anemia? |
| 35. Yes No Asthma, TB, emphysema, other lung disease? | 46. Yes No VD (syphilis or gonorrhea)? |
| 36. Yes No Hepatitis, other liver disease? | 47. Yes No Herpes? |
| 37. Yes No Stomach problems? | 48. Yes No Kidney, bladder disease? |
| 38. Yes No Allergies to: Drugs, foods, medication, latex? | 49. Yes No Thyroid, adrenal disease? |
| 39. Yes No Family history of diabetes, heart problems, tumors? | 50. Yes No Diabetes? |

IV. Do You Have or Have You Had:

- | | |
|------------------------------------|--------------------------------|
| 51. Yes No Psychiatric care? | 56. Yes No Hospitalization |
| 52. Yes No Radiation treatment? | 57. Yes No Blood transfusions? |
| 53. Yes No Chemotherapy? | 59. Yes No Surgeries? |
| 54. Yes No Prosthetic heart valve? | 60. Yes No Contact lenses? |
| 55. Yes No Artificial joint? | |

V. Are you taking?

- | | |
|---|---------------------------------|
| 61. Yes No Recreational Drugs? | 63. Yes No Tobacco in any form? |
| 62. Yes No Drugs, medications, over-the-counter medicines
(Including Aspirin), natural remedies? | 64. Yes No Alcohol? |

VI. Women Only:

- | | |
|---|--|
| 65. Yes No Are you or could you be pregnant or nursing? | 66. Yes No Taking birth control pills? |
|---|--|

VIII. All Patients:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? _____

To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of any changes in my health and/or medication.

Patient Signature: _____ Date: _____ Doctor's Signature: _____ Date: _____