DENTAL/MEDICAL HISTORY

Dental Information:

Patient Name_____ ♦ Reason for today's visit: ☐Exam ☐Emergency ☐Consultation

Are you in pain? ☐Yes ☐No ♦ How Long?_____ ♦ Where?_____

Please indicate any of the following problems you are experiencing currently or have had in the past: ☐Discomfort/Clicking/Popping in the Jaw ☐Lost/Broken Filling (s) ☐Broken/Chipped Tooth ☐Red/Swollen/Bleeding Gums ☐Sensitive Teeth/Gums ☐Bad Breath

☐Blisters/Sores In or Around Mouth ☐Stained Teeth ☐Other:_____

Do you require *Pre-Medication* prior to dental procedures? ☐Yes, Why?_____ ☐No ☐Don't Know

Prior Dentist:_____ ♦ Phone _____ ♦ Last Dental Exam:_____ ♦ Last X-rays _____

Have your past experiences in a dental office always been positive?_____

Do you or have you in the past ever smoked or chewed tobacco products? _____

How many times a day do you brush? _____ ♦ How many times a week do you floss? _____

How would you rate your smile? (*Worst*) 1 2 3 4 5 6 7 8 9 10 (*Best*) ♦ Are you interested in teeth whitening?_____

Medical History

Are you currently under a physician's care? ☐Yes ☐No Why?_____ Doctor's Name:_____Phone_____

When was the date of your last physical exam? _____

Have you ever been hospitalized or had any major surgeries? ☐Yes ☐No When/Why?:_____

Are you currently taking prescription medications? ☐Yes ☐No What?:_____

Are you currently taking over the counter medications and/or herbal supplements? ☐Yes ☐No What?:_____

Are you allergic to any medications/substances? Including but not limited to:

☐Aspirin ☐Penicillin ☐Codeine ☐Metal ☐Latex Rubber ☐Other_____

Women (Please Check): ☐Pregnant/Trying to Convieve ☐Nursing ☐Taking Oral Contraceptives: _____

Are you aware that antibiotics will negate the effects of oral contraceptives? ☐Yes ☐No

Are you currently taking any bisphosphonates for osteoporosis? ☐Yes ☐No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y / N…. Heart Attack/Stroke (If yes, What year:_____)
Y / N…. Irregular Heartbeat/Pacemaker
Y / N…. Heart Murmur……. w/ Regurgitation (**Y / N**)
Y / N…. Rheumatic Fever…….any damage to Heart Valve (**Y / N**)
Y / N…. Mitral Valve Prolapse
Y / N…. Artificial Heart Valves
Y / N…. Heart Disease
Y / N…. History of Infective Endocarditis
Y / N…. Congenital Heart Defect
Y / N…. Chest Pains
Y / N…. High/Low Blood Pressure
Y / N…. Prosthetic/Joint Replacements (If yes, What year:_____)
Y / N…. Anemia
Y / N…. Thyroid Problems

Y / N…. Kidney Problems
Y / N…. Liver Problems
Y / N…. Respiratory Problems
Y / N…. Sinus Problems
Y / N…. Emphysema
Y / N…. Asthma…….do you carry Albuterol (**Y / N**)
Y / N…. Difficulty Breathing
Y / N…. Stomach Problems/Ulcers
Y / N…. Psychiatric Problems
Y / N…. Nervousness
Y / N…. Venereal Disease
Y / N…. Alcohol/Drug Abuse
Y / N…. Tuberculosis (TB)

Y / N…. Jaw Problems / TMD
Y / N…. Cancer/Tumors
Y / N…. Chemotherapy
Y / N…. Radiation Treatment
Y / N…. Shingles
Y / N….HIV+/AIDS
Y / N…. Arthritis/Rheumatism
Y / N…. Fainting/Seizures/Epilepsy
Y / N…. Severe/Frequent Headaches
Y / N…. Back/Neck Pain
Y / N…. Diabetes/Hypoglycemia
Y / N…. Leukemia
Y / N…. Glaucoma

Have you ever had any other serious illness not listed above? ☐Yes ☐No Explain:_____

Do you wish to talk to the Dentist privately about any problem? ☐Yes ☐No

Authorization

I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND I ALSO UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE INFORMATION I HAVE PROVIDED.

Patient/Guardian Signature: _____ Date_____

Doctors Signature:_____ Date:_____