PATIENT MEDICAL HISTORY

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NAME:_________________________________ DATE OF BIRTH:_______/________/_______ DATE:________________

Although dental personnel primarily treat the area in and around your mouth, your mouth can affect your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dental care you will receive. Thank you for answering the following questions.

Other than regular physical exams, have you been seen by a doctor in the last 2 years for a health concern? Y /N
If yes please specify ____
Have you had any jaw related injuries? Y/N **If yes** ____
Please list ALL medications or supplements you are taking____
____
Have you had a joint replacement or heart valve replacement which requires taking an antibiotic prior to dental appointments? Y/N
If Yes, reason and medication prescribed:____
Do you use tobacco? Y/N Please circle if daily use of: Cigarettes/chewing tobacco/e-cig/marijuana/cigar/pipe
Do you drink alcohol? Never Occasionally Frequently Daily

WOMEN ONLY: Pregnant? **Y/N** Trying to get pregnant **Y/N** Nursing? **Y/N** Taking oral contraceptives? **Y/N**
Have you ever taken medications for Osteoporosis? (Including Fosamax, Boniva or Actonel) **Y/N**

Are you allergic to any of the following? (Please circle) Aspirin Amoxicillin Penicillin Codeine Acrylic Latex Sulfa Local Anesthetics Other: ____

Please circle any past or present conditions that apply:

Acid reflux/GERD/Ulcers
AIDS/HIV Positive
Alzheimer's Disease/Dementia
Anxiety/Depression
ANY **Blood Disease** _________________
ANY Breathing Problem ______________
ANY **Heart Problem** _________________
Arthritis/Gout
Artificial heart valve
Artificial Joint (date?) ______________
Autism Spectrum
Auto Immune Disease (Ankylosing Spondylitis, Celiac Disease, Lupus, Psoriasis, Rheumatoid Arthritis, Sjögren's, Vasculitis)
Cancer/Leukemia
Cognitive Impairment

Cold Sores/Fever blisters
Cystic Fibrosis
Diabetes Type 1 or Type 2
Digestive disease (Inflammatory bowel disease-Crohn's, Ulcerative colitis)
Dry Mouth
Epilepsy/Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent headaches
Hay Fever/Seasonal allergies/Sinus Issues
Hepatitis A, B, C
High Blood Pressure/Low Blood Pressure
High cholesterol
Hives or Rash
Kidney problems

Liver disease
Multiple Sclerosis
Muscular Dystrophy
Osteoporosis
Pacemaker
Parathyroid or Thyroid disease Hashimoto's or Grave's
Parkinson's disease
Radiation treatments/Chemotherapy
Scleroderma
Shingles
Sleep Apnea-diagnosed
Stroke
TMJ/pain in jaw joints
Tuberculosis
Tumors or Growths

Any other serious medical problem not listed above ________________________________
Are you currently taking a controlled substance? Y /N Please circle medication:
Pain medications: Demerol, Tramadol, Hydromorphone (Dilaudid), Soma, Talwin, Oxycodone, Hydrocodone, Lyrica, Fentanyl or Tylenol with codeine
Stimulants: Adderall, Ritalin, Dexedrine **Anxiety/Depression medications:** Xanax, Ativan, Valium
Other Medications: Lomotil , Ambien, Anabolic Steroids or Testosterone **Other**____________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be detrimental to my health. It is my responsibility to inform the dental office of any changes in medical status.
Signature of Patient, Parent or Guardian X____

PATIENT NAME: ____BIRTHDATE____/____/____

HOW MANY TIMES PER DAY DO YOU BRUSH YOUR TEETH? ________ HOW OFTEN DO YOU FLOSS? _____DAILY/WEEKLY
WHAT TYPE OF TOOTHBRUSH ARE YOU CURRENTLY USING? SOFT MEDIUM HARD ELECTRIC TOOTHBRUSH
WHAT TYPE OF TOOTHPASTE ARE YOU CURRENTLY USING? _____________________MOUTHRINSE? ________________
WHAT TYPE OF WATER DO YOU HAVE? WELL WATER OR CITY WATER

ARE YOU CURRENTLY EXPERIENCING ANY DISCOMFORT, CHANGE OR CONCERN WITH ANY AREA OF YOU MOUTH? Y/N
IF YES, PLEASE EXPLAIN: ____

HAVE YOU EVER BEEN TOLD BY A DENTIST THAT YOU HAVE PERIODONTAL DISEASE OR DO YOU HAVE A FAMILY HISTORY OF PERIODONTAL DISEASE? Y/N IF YES: ____

PLEASE INDICATE AN ANSWER FOR EACH BEHAVIOR/HABIT THAT APPLIES TO YOU:

BITE CHEEK	NEVER	OFTEN	ALWAYS
GRIND OR CLENCH TEETH	NEVER	OFTEN	ALWAYS
TONGUE THRUST	NEVER	OFTEN	ALWAYS
MOUTH BREATHER	NEVER	OFTEN	ALWAYS
EATING DISORDER	NEVER	OFTEN	ALWAYS
BITE NAILS	NEVER	OFTEN	ALWAYS
SUCK FINGER/THUMB	NEVER	OFTEN	ALWAYS
TOOTHPICK/STIMULATOR	NEVER	OFTEN	ALWAYS
CHEWING GUM	NEVER	OFTEN	ALWAYS
CANDY	NEVER	OFTEN	ALWAYS
SOFT DRINKS	NEVER	OFTEN	ALWAYS
SPORTS DRINKS	NEVER	OFTEN	ALWAYS
BAD BREATH	NEVER	OFTEN	ALWAYS
TEETH WHITENING	NEVER	OFTEN	ALWAYS

OTHER: ____

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:
ARE YOUR TEETH SENSITIVE TO:

HOT OR COLD	PRESENT	PAST	NEVER
BITING OR CHEWING	PRESENT	PAST	NEVER
SWEETS	PRESENT	PAST	NEVER

HAVE YOU EVER HAD:

ORTHODONTIC TREATMENT	PRESENT	PAST	NEVER
BITE PLATE OR GUARD	PRESENT	PAST	NEVER
ORAL SURGERY	PRESENT	PAST	NEVER
SERIOUS INJURY TO THE MOUTH	PRESENT	PAST	NEVER

WOULD YOU LIKE TO IMPROVE THE APPEARANCE OF YOUR SMILE? YES/NO IF SO, HOW? _________________________
____
____
____