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	____ Ibuprofen
____ Codeine	____ Sulfa Drugs, Sulfites, Sulfides
____ Nitrous Oxide	____ Acetaminophen/Tylenol
____ Penicillin	____ Barbiturates
____ Erythromycin	____ Tetracycline
____ Other antibiotics _____	____ Local Anesthesia (Novocaine)
____ Latex, Metals, Plastic	____ 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?** _____
☐	☐	Do you smoke or use chewing tobacco?
☐	☐	Do you smoke or ingest marijuana?
☐	☐	Do you drink alcohol? If yes, how often and in what quantity? _____

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

____Osteoporosis	____ Bisphosphonate therapy (e.g. Boniva)	____ Shingles
____Heart disease or heart attack	____Asthma	____ Glaucoma
____Abnormal blood pressure	____Diabetes	____ Headaches
____Heart murmur/mitral valve prolapse	____Thyroid issues	____ Fainting
____Rheumatic fever	____ Hepatitis A, B, C	____ Hard of Hearing
____Heart pacemaker	____ Hemophilia	____ Anaphylaxis
____Heart surgery	____ Epilepsy or seizures	____ Allergies
____Stroke	____ Psychiatric treatment	____ Blood Transfusion
____Kidney disease	____ Artificial joints	____ Herpes
____History of drug addiction /alcoholism	____ Anemia	____ Ulcers
____Arthritis	____ AIDS or HIV+	____ Liver Disease
____Anemia	____ Congenital heart lesions	____ Sickle Cell Disease
____Bleeding disorders	____ Tuberculosis or lung disease	____ Radiation Treatment
____ Sinus issues	____ Hay fever	____ Tumor or Malignancy
____ Jaundice	____ Infectious mononucleosis (mono)	____ Implants/artificial joints
____Sexually transmitted/venereal disease	____Cancer/chemotherapy/radiation	

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: _____

Patient Review and Update of Form: *please review this form annually*, note any changes, sign and date in the spaces below:

Revision Signature: _____ **Date**:_____