MEDICAL-DENTAL HISTORY

Name (Dr., Mr., Ms., Mrs.): _____

What should we call you? _____

Date of birth: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Referred by:_____

Employer:_____

Occupation:_____

Dental Insurance: ☐ Yes ☐No

Social Security Number:_____

Dentist: _____
(Name) (Phone Number)

Family Physician: _____
(Name) (Phone Number)

Cardiologist: _____
(Name) (Phone Number)

Pain Management: _____
(Name) (Phone Number)

Other Physician:_____
(Name) (Phone Number)

Other Physician:_____
(Name) (Phone Number)

Emergency Contact: _____
(Name) (Phone Number)

Pharmacy: _____
(Name) (Phone Number) (Address)

Height & Weight: _____
(Necessary for prescribing RX)

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1. Are you currently under the care of a physician? ☐ Yes ☐No

2. Please list dates and reasons for hospitalizations_____

_____

3. Please list allergies to drugs or medications_____

_____

Have you ever been treated for the following conditions:

4. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? If yes, please specify._____

_____

5. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? If yes, please specify. _____

_____

Have you ever or are you currently been treated for the following conditions:

6. Excessive bleeding: ☐ Yes ☐ No List medications: _____

7. Breathing problems, asthma, tuberculosis, hay fever: ☐ Yes ☐ No List medications: _____

8. Thyroid disease or trouble: : ☐ Yes ☐ No List medications: _____

9. Cancer, x-ray treatment, or chemotherapy: ☐ Yes ☐ No List medications: _____

10. Hepatitis, jaundice, or liver disease: ☐ Yes ☐ No List medications: _____

11. Kidney problems or renal dialysis: ☐ Yes ☐ No List medications: _____

12. STD's or HIV: ☐ Yes ☐ No List medications: _____

13. A stroke, convulsions, or fainting spells: ☐ Yes ☐ No List medications: _____

14. Tumors or growths: ☐ Yes ☐ No List medications: _____

15. Arthritis or rheumatism: ☐ Yes ☐ No List medications: _____

16. High cholesterol: ☐ Yes ☐ No List medications: _____

17. High blood pressure: ☐ Yes ☐ No List medications: _____

18. Diabetes: ☐ Yes ☐ No List medications: _____

If yes: ☐Type 1 ☐ Type 2 When was your last AIC test result: _____ How often are you tested: _____

Do you take any of the following:

19. Pain medications: ☐ Yes ☐ No List medications: _____

20. Anxiety or mind altering medications: ☐ Yes ☐ No List medications: _____

21. Sleep medications: ☐ Yes ☐ No List medications: _____

22. Osteoporosis medications: ☐ Yes ☐ No List medications: _____

23. Aspirin and/or blood thinners: ☐ Yes ☐ No If yes, dose:
_____

24. Vitamin or herbal supplements: ☐ Yes ☐ No List medications: _____

25. Please list any other medications you are taking and for what reason: _____

_____

26. Weight-loss supplements(prescription and/or over-the-counter): ☐ Yes ☐ No List medications: _____

27. Have you ever had a serious injury to your head or neck? If yes, describe. _____

_____

28. Do you smoke? ☐ Yes ☐ No If yes, describe type and frequency: _____

29. For women: Are you pregnant or breastfeeding? _____

DENTAL HISTORY

30. What would you like done for your mouth? _____

31. Are you satisfied with the appearance of your teeth? _____

32. Are you satisfied with your ability to chew? _____

33. Does food catch between your teeth: ☐ Yes ☐ No

34. Are any of your teeth sensitive to heat, cold, or pressure: ☐ Yes ☐ No

35. Do you snore: ☐ Yes ☐ No

36. Have you been diagnosed with sleep apnea: ☐ Yes ☐ No

37. Do you get headaches or migraines: ☐ Yes ☐ No

38. Do you grind your teeth or clench your jaws: ☐ Yes ☐ No

39. Do you have pain or clicking in the jaw joint around your ear: ☐ Yes ☐ No

40. Have your jaw muscles ever been sore: ☐ Yes ☐ No If yes, please describe_____

41. Are there any sores or growths in your mouth: ☐ Yes ☐ No

42. Do any of your teeth ache: ☐ Yes ☐ No

43. How often do you have your teeth cleaned? _____ Date of last cleaning: _____

In respect to previous dental treatment have you:

44. Ever had a bad dental experience: ☐ Yes ☐ No

45. Had an allergic reaction: ☐ Yes ☐ No If yes, please describe: _____

46. Had abnormal bleeding: ☐ Yes ☐ No

47. Other complications during or following dental treatment: ☐ Yes ☐ No If yes, please describe:_____

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the above questions have been accurately answered.

Permission to release health information:
I grant the right to the dentist to release health information obtained from me, and information about my dental treatment, to third party payors and/or health care practitioners.

Person completing this form:

_____ _____ _____
Signature Printed Name Date

If other than patient, indicate relationship: _____