Medical History

First Name: _____ Last Name: _____ Date of Birth: _____

Name of Physician: _____ Date Last Physical Exam: _____

	Y	N	If yes, please explain:
Have you ever been hospitalized or had a major injury?	☐	☐	
Have you ever had a serious head or neck injury?	☐	☐	
Do you have any physical limitations (back issues, dexterity with brushing) that we should know?	☐	☐	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐	☐	
Do you use tobacco or marijuana?	☐	☐	

Are you allergic to any of the following?

☐ Penicillin ☐ Codeine ☐ Aspirin, Motrin, Tylenol ☐ Local Anesthetic ☐ Acrylic ☐ Metal ☐ Latex

☐ Other If yes, please explain: _____

Women, are you:

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Do you have, or have you had, any of the following?

	Y	N		Y	N		Y	N
Digestive Disorders	☐	☐	Stroke	☐	☐	Renal Dialysis	☐	☐
Ulcers	☐	☐	Date: ___ / _____			Liver Disease	☐	☐
Acid Reflux	☐	☐	Heart Disease	☐	☐	Hepatitis (Type ___)	☐	☐
Sinus Trouble	☐	☐	Heart Attack	☐	☐	Yellow Jaundice	☐	☐
Tonsillitis	☐	☐	Date: ___ / _____			Osteoporosis	☐	☐
Autoimmune Disease	☐	☐	High Blood Pressure	☐	☐	Cancer	☐	☐
Arthritis	☐	☐	Low Blood Pressure	☐	☐	Chemotherapy	☐	☐
Artificial Joint Replacement	☐	☐	Heart Murmur	☐	☐	Radiation	☐	☐
Premed Needed?	☐	☐	Pacemaker	☐	☐	Neurologic Disorder	☐	☐
Cold Sores/Fever Blisters	☐	☐	Mitral Valve Prolapse	☐	☐	Epilepsy/Seizures	☐	☐
Breathing Problems	☐	☐	Congenital Heart Disorder	☐	☐	Alzheimer's Disease	☐	☐
Asthma	☐	☐	Artificial Heart Valve	☐	☐	Dementia	☐	☐
Tuberculosis	☐	☐	High Cholesterol	☐	☐	Psychiatric Care	☐	☐
Hormone Disease	☐	☐	Bleeding Disorder	☐	☐	Depression	☐	☐
Diabetes HbA1c: _____	☐	☐	Anemia	☐	☐	Drug Use	☐	☐
Hypoglycemia	☐	☐	AIDS/HIV Positive	☐	☐	ADD/ADHD	☐	☐
Thyroid Disease	☐	☐	Sickle Cell Disease	☐	☐	Autism	☐	☐
Glaucoma	☐	☐	Kidney Disease	☐	☐			

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:

_____

_____

Please list all medication, supplements, and vitamins you are currently taking:

Drug	Purpose	Drug	Purpose

Dental History

What is your immediate concern? _____

Previous Dentist: _____

I Routinely Saw My Dentist Every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not Routinely

How Long Were You a Patient? _____ Months/Years Approximate Date of Last Radiographs: _____

Please check off all the things that would keep you from pursuing your dental treatment:

☐ Cost ☐ Fear ☐ Lack of Time ☐ Lack of Importance ☐ Other: _____

Please answer the following questions so that we may get to know you better:

PERSONAL HISTORY	**Y**	**N**
Are you fearful of dental treatment?	☐	☐
How fearful, on a scale of 1 (least) to 10 (most)? ___		
Have you ever had complications from past dental treatment?	☐	☐
Have you ever had trouble getting numb in the past?	☐	☐

SMILE CHARACTERISTICS	**Y**	**N**
Are you self-conscious about the appearance of your teeth?	☐	☐
Would you like your teeth to look whiter?	☐	☐
Have you ever had orthodontics in the past?	☐	☐
Do you like the shape of your teeth?	☐	☐

BITE AND JAW JOINT	**Y**	**N**
Have you ever been diagnosed with a problem with either jaw joint?	☐	☐
Does your jaw click, pop, or make noise when you open/close?	☐	☐
Do you have pain or tenderness in your jaw joint when you open, close, or chew?	☐	☐
Has your jaw ever locked open or close?	☐	☐
Do you have frequent headaches? If so, how often? _____	☐	☐
Do you clench or grind your teeth, or ever been told you do?	☐	☐
Have you ever had trauma to your chin or jaw?	☐	☐

TOOTH STRUCTURE	**Y**	**N**
Have you ever had a toothache, cracked filling, or broken tooth?	☐	☐
Are any teeth sensitive to hot, cold, biting, or sweets?	☐	☐
Do you avoid brushing any part of your mouth?	☐	☐
Do you have a dry mouth?	☐	☐
Have you ever had a tooth extracted?	☐	☐

GUM AND BONE	**Y**	**N**
Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
Is there anyone in your family with a history of periodontal disease?	☐	☐
Have you ever experienced gum recession?	☐	☐
Do your gums bleed when brushing, flossing, or eating?	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐

SLEEP	**Y**	**N**
Do you snore?	☐	☐
Do you feel tired, fatigued, or sleepy during the day time?	☐	☐
Have you ever been diagnosed with sleep apnea?	☐	☐

The questions on this form have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian: _____ Date: _____