Medical and Dental Health History
(Confidential)

Date ____________

Patient Name ____ Birthdate ____________________
Last First Middle

PLEASE READ CAREFULLY
Welcome to our office. We strive to provide for you the most thorough and individualized treatment possible within our scope of care. So that we may do this, we would appreciate your time and careful attention to the health and dental history. PLEASE REMEMBER that your past health history is as important as your current health status. If you have any questions or need help filling this out, please do not hesitate to ask. Thank you.

Medical History

Physician's Name ____________________________________ Last Seen ______________________________
Address ____ Phone ______________________________
Are you currently under the care of a Physician? ____
Previous Dentist ____________________________________ Last Seen ______________________________

Have you had or do you currently have (Check all that apply):

- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Clots
- ☐ Bone/Joint Disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Chest Pain
- ☐ Cortisone Treatments
- ☐ Cough Up Blood
- ☐ Cough, Persistant
- ☐ Diabetes
  - ___ Insulin
  - ___ Oral Rx
  - ___ Diet
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Frequent Cold/Sore Throat
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Problems
  - ___ Artificial Heart Valves
  - ___ Atrial Fibrillation
  - ___ Angioplasty
  - ___ Congestive Heart Failure
  - ___ Irregular Heartbeat
    - __ Slow __ Rapid
- ___ By-Pass Surgery
- ___ Heart Disease
- ___ Heart Attack
- ___ High Blood Pressure
- ___ Low Blood Pressure
- ___ Mitral Valve Prolapse
- ___ Pacemaker
- ☐ Hepatitis
  - __ A
  - __ B
  - __ C
- ☐ Hemophilia
- ☐ HIV Positive ☐ AIDS
- ☐ Hormonal Problems
- ☐ Hypoglycemia
- ☐ Implants
- ☐ Jaw Pain
- ☐ Kidney Dialysis
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Nervous Problems
- ☐ Yeast Infections __Reoccuring?
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems- Allergies/Hay Fever
- ☐ Skin Cancer
- ☐ Skin Rash
- ☐ Strokes
- ☐ Strokes "Mini" (T.I.A.'s)
- ☐ Surgeries (List Below)
- ☐ Blood Transfusion
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths, or Malignancies
- ☐ Ulcers
- ☐ Venereal Disease
  - __Syphillis __Gonorrhea
  - __Herpes __Chlamydia

Women

Are you Pregnant? ☐ Y es ☐ No
Are you taking birth control pills? ☐ Y es ☐ No
Are you taking hormone replacement therapy? ☐ Y es ☐ No

Surgeries (List any surgeries)

____
____
____

Allergies or Reactions To (Check all the apply):

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbituates, Sedatives, Sleeping Pills, Epinephrine
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Morphine
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Ibuprofen (Advil)
- ☐ Nickel
- ☐ Other: ________________
  ____
  ____

Medications (List all Prescription & Non-Prescription)

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____
____
____
____

(Continued on Other Side)

Dental History

Date of Last Dental X-rays: ____________________________

Any trouble associated with previous dental treatment? (If yes, describe) ______________________________________

Any discomfort in your mouth at this time (If yes, describe)

____

____

Any injury or trauma to head or neck? ____

Any sensitivities to temperature, sweets, or pressure? ____

Do you have or have you had any blisters, swellings, or sores on you gums, cheeks, or lips? ________________________

Have you ever had T.M.J problems? _______________________ Do you clench or grind your teeth? _______________

Have you had your teeth straightened (Orthodontics)? ____

Have you had gum surgery (Periodontics)? ____

Have you ever had a gum infection, pyorrhea or trenchmouth? ____

Have you ever had oral surgery? ____

Do your gums bleed when you brush or eat? ____

Do you clean between your teeth? With what? ____

What type of bristles are in your toothbrush(Soft/Medium/Hard)? ____

Do you have any disease, condition, or problem not listed above? If so, explain: ________________________________

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Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____ Date: ______________________________