Medical History

Although our Dental Team primarily treats areas in and around your mouth the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible, Thank You!

Are you under a physician's care now? □ Yes □ No If yes, please explain: ______________________________

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Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain: ______________________________

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Have you ever had a serious head or neck injury? □ Yes □ No If yes, please explain: ______________________________

Have you ever taken, Phen-Fen, Redux, Fosamax? □ Yes □ No

Are you on a special diet? □ Yes □ No If yes, please explain: ______________________________

Do you use tobacco? □ Yes □ No

Do you use controlled substances? □ Yes □ No

If yes, please explain: ______________________________

Please list any medications, pills, or drugs you are taking: ______________________________

Are you allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Other

If yes please explain: ______________________________

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Are you pregnant or trying to get pregnant? □ Yes □ No

Taking oral contraceptives? □ Yes □ No

Nursing? □ Yes □ No

Condition	Yes / No
Heart Problems	□ Yes □ No
Angina	□ Yes □ No
Artificial Heart Valve	□ Yes □ No
Heart Valve Problem	□ Yes □ No
Chest Pains	□ Yes □ No
Congenital Heart Disease	□ Yes □ No
Heart Attack/Failure	□ Yes □ No
Heart Murmur	□ Yes □ No
Heart Trouble/Disease	□ Yes □ No
Heart Pace Maker	□ Yes □ No
High Blood Pressure	□ Yes □ No
Irregular Heartbeat	□ Yes □ No
Low Blood Pressure	□ Yes □ No
Mitral Valve Problems	□ Yes □ No
Rheumatic Fever	□ Yes □ No
Scarlet Fever	□ Yes □ No
Stroke	□ Yes □ No
AIDS/HIV Positive	□ Yes □ No
Genital Herpes	□ Yes □ No
Hepatitis A, B, or C	□ Yes □ No
Herpes or other STD	□ Yes □ No
Shingles	□ Yes □ No
Syphilis	□Yes □ No

Condition	Yes / No
Blood Problems	□ Yes □ No
Anemia	□ Yes □ No
Blood Disease	□ Yes □ No
Blood Transfusion	□ Yes □ No
Bruise easily	□ Yes □ No
Excessive Bleeding	□ Yes □ No
Hemophilia	□ Yes □ No
Cancer	□ Yes □ No
Chemotherapy	□ Yes □ No
Leukemia	□ Yes □ No
Tumors or Growths	□ Yes □ No
Taking bisphosphonate	□ Yes □ No
Respiratory problems	□ Yes □ No
Asthma	□ Yes □ No
Emphysema	□ Yes □ No
Tuberculosis	□ Yes □ No
Hay Fever	□ Yes □ No
Frequent Cough	□ Yes □ No
Sinus	□ Yes □ No
Hives or Rash	□ Yes □ No
Diabetes	□ Yes □ No
Type ____________	
Urinate more than 6 times a day	□ Yes □ No
Thirsty or mouth is dry much of the time	□ Yes □ No
Family history of diabetes	□ Yes □ No
Hypoglycemia	□ Yes □ No

Condition	Yes / No
Intestinal Problems	□ Yes □ No
Ulcers	□ Yes □ No
Weight gain or loss	□ Yes □ No
Special Diet	□ Yes □ No
Constipation/Diarrhea	□ Yes □ No
Kidney or bladder problems	□ Yes □ No
Liver Disease	□ Yes □ No
Frequent Diarrhea	□ Yes □ No
Bone or Joint problems	□ Yes □ No
Arthritis	□ Yes □ No
Back or neck pain	□ Yes □ No
Joint replacement (e.g., total hip, pins, or implants)	□ Yes □ No
Stomach Disease	□ Yes □ No
Yellow Jaundice	□ Yes □ No
Glaucoma	□ Yes □ No
Venereal Disease	□ Yes □ No
Thyroid problems	□ Yes □ No
Hyper or Hypo:______________	
History of head injury?	□ Yes □ No
Fainting Spells, Seizures, or Epilepsy	□ Yes □ No
Other neurological disease	□ Yes □ No
History of alcohol or drug abuse?	□ Yes □ No
Do you drink?	□ Yes □ No
if so how much? ____________________	
Do you smoke?	□ Yes □ No
if so how much? ____________________	

During Past 12 months, have you taken any of the following?

Antibiotics or sulfa drugs	□ Yes □ No	Anticoagulants (e.g., Coumadin)	□ Yes □ No	Insulin, Orinase, or similar drug	□ Yes □ No
Natrual Remedies	□ Yes □ No	Nonprescription drug/supplements	□ Yes □ No	Aspirin	□ Yes □ No
Nitroglycerin	□ Yes □ No	Digitalis or drugs for heart trouble	□ Yes □ No	Plavix	□ Yes □ No

Other ____

Dental History

Are you apprehensive about dental treatment? □ Yes □ No

Have you had problems with previous dental treatment? □ Yes □ No

Do you gag easily? □ Yes □ No

Do you wear dentures? □ Yes □ No

Does food catch between your teeth? □ Yes □ No

Do you have difficulty in chewing your food? □ Yes □ No

Do you chew on only one side of your mouth? □ Yes □ No

Do you avoid brushing any part of your mouth because of pain? □ Yes □ No

Do your gums bleed easily? □ Yes □ No

Do your gums bleed when your floss? □ Yes □ No

Do your gyms feel swollen or tender? □ Yes □ No

Have you ever noticed slow-healing sores in or about your mouth? □ Yes □ No

Are your teeth sensitive? □ Yes □ No

Do you feel twinges of pain when y our teeth come in contact with:

- Hot foods or liquids? □ Yes □ No
- Cold foods or liquids? □ Yes □ No
- Sours? □ Yes □ No
- Sweets? □ Yes □ No

Do you take fluoride supplements? □ Yes □ No

Are you dissatisfied with the appearance of your teeth? □ Yes □ No

Do you prefer to save your teeth? □ Yes □ No

Do you want complete dental care? □ Yes □ No

How often do you brush? _________________

How often do you floss? _________________

Does your jaw make noise so that it bothers you or others? □ Yes □ No

Do you clench or grind your jaws frequently? □ Yes □ No

Do your jaws ever feel tired? □ Yes □ No

Does your jaw get stuck so that you can't open freely? □ Yes □ No

Does it hurt when you chew or open wide to take bite? □ Yes □ No

Do you have earaches or pain in front of the ears? □ Yes □ No

Do you have any jaw symptoms or headaches upon awaking in the morning? □ Yes □ No

Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? □ Yes □ No

Do you find jaw pain or discomfort extremely frustrating or depressing? □ Yes □ No

Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? □ Yes □ No

Do you have a temporomandibular (jaw) disorder (TMD)? □ Yes □ No

Do you have pain in the face, cheeks, jaw, joints, throat, or temples? ☐ Yes □ No

Are you unable to open your mouth as far as you want? □ Yes □ No

Are you aware of an uncomfortable bite? □ Yes □ No

Have you had a blow to the jaw (trauma)? □ Yes □ No

Are you a habitual gum chewer or pipe smoker? □ Yes □ No

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my child's) health I will not hold my Dentist or any members of his/her Dental Team responsible to errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X**_____________________________________ Date: __________________________