



# Medical and Dental History

Name \_\_\_\_\_ Preferred or Nickname \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Date of last visit \_\_\_\_\_

Check if you have had any of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Arthritis/Rheumatism    | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Blood Disease     |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> Fainting Tendency |
| <input type="checkbox"/> Heart Attack/Trouble    | <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Kidney Trouble  |  |
| <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Asthma          |  |
| <input type="checkbox"/> HIV or AIDS             | <input type="checkbox"/> Sinus Trouble   |  |
| <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Lung Disease    |  |
| <input type="checkbox"/> Joint Replacement       | <input type="checkbox"/> Radiation       |  |

Women: Are you pregnant:  Y  N

If yes, due date \_\_\_\_\_

Nursing  Y  N

Birth control pills  Y  N

Have you had any health problems, serious illnesses or operations?  Yes  No If yes, explain: \_\_\_\_\_

Are you currently taking any medications? If yes, list all: \_\_\_\_\_

Do you have any drug allergies? If yes, list all: \_\_\_\_\_

Check any of the following that you are taking OR have taken:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anticoagulants /Blood Thinners   | <input type="checkbox"/> Sedatives     | <input type="checkbox"/> Steroids        |
| <input type="checkbox"/> Cortisone Drugs  | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Phen Phen/Redux |
| <input type="checkbox"/> Bisphosphonates (Boniva, Actonel, Fosamax, Zometa, Reclast, Aredia, etc) |  |  |

What would you like us to do today? \_\_\_\_\_

Date of last dental care? \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Have you ever had an adverse reaction during or in conjunction with a medical or dental procedure?  Yes  No

If yes, explain: \_\_\_\_\_

Check if you have had problems with any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad breath              | <input type="checkbox"/> Food collection between teeth  | <input type="checkbox"/> Sensitivity to sweets     |
| <input type="checkbox"/> Bleeding gums           | <input type="checkbox"/> Grinding or clenching teeth    | <input type="checkbox"/> Sensitivity to biting     |
| <input type="checkbox"/> Clicking or jaw popping | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores or growths in mouth |

Do you require antibiotics before dental treatment?  Yes  No If yes, for what condition? \_\_\_\_\_

Have you ever had gum treatment?  Yes  No If yes, when? \_\_\_\_\_

Is there anything you would like to change about your smile?  Yes  No If yes, explain: \_\_\_\_\_

Are you happy with the color of your teeth?  Yes  No

Have you ever had any unfavorable dental experiences?  Yes  No If yes, explain: \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

How can we accommodate you better during your dental visit? \_\_\_\_\_

The above information is true to the best of my knowledge:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_