

Medical and Dental History

Heart and Circulatory System								
Heart Attack	Yes	No	Congestive Heart Failure	Yes	No	Heart Murmur	Yes	No
Heart Rhythm Disorder	Yes	No	Damaged Heart Valves	Yes	No	High Blood pressure	Yes	No
Cardiovascular Disease	Yes	No	Stroke	Yes	No	Chest Pain Upon Exertion	Yes	No
Arteriosclerosis	Yes	No	Angina	Yes	No	Pacemaker	Yes	No
Rheumatic Heart Disease	Yes	No	Mitral valve prolapse	Yes	No	Abnormal/Excessive Bleeding	Yes	No
Anemia	Yes	No	Other congenital heart defects	Yes	No	Blood Disease	Yes	No
Low Blood Pressure	Yes	No	Blood Transfusion	Yes	No	Hemophilia	Yes	No
Lungs and Breathing								
Asthma	Yes	No	Emphysema	Yes	No	Bronchitis	Yes	No
Severe Coughing	Yes	No	Respiratory disease	Yes	No	Sinus Trouble	Yes	No
Tuberculosis	Yes	No						
Stomach and Gut								
G.E. Reflux (Heartburn)	Yes	No	Ulcers	Yes	No	Gastrointestinal disease	Yes	No
Mental Health								
Psychiatric Care	Yes	No	Anxiety	Yes	No	Alzheimer's/Dementia	Yes	No
Eating disorder	Yes	No	Neurological disorders	Yes	No	Drug Addiction	Yes	No
Conditions and Diseases								
Autoimmune disease	Yes	No	TMJ	Yes	No	Osteoporosis/Paget disease	Yes	No
Aids or HIV	Yes	No	Sexually Transmitted infection	Yes	No	Epilepsy	Yes	No
Cancer/Chemotherapy	Yes	No	Tumors or Growths	Yes	No	Hepatitis, Jaundice or Liver disease	Yes	No
Diabetes	Yes	No	Arthritis	Yes	No		Yes	No
Back Problems	Yes	No	Swollen glands in Neck	Yes	No	Severe Headaches/Migraines	Yes	No
Recurrent Infections	Yes	No	Malnutrition	Yes	No	Severe or rapid weight loss	Yes	No
Chronic pain	Yes	No	Fainting spells or seizures	Yes	No	Frequent headaches	Yes	No
Kidney problems	Yes	No	Systemic Lupus erythematosus	Yes	No	Thyroid problems	Yes	No
Hearing difficulties	Yes	No	Glaucoma	Yes	No	Rheumatic fever	Yes	No
Night Sweats	Yes	No	Low pain tolerance	Yes	No	Gout	Yes	No
Are you Pregnant?	Yes	No	Are you Nursing?	Yes	No	Are you taking birth control or hormone replacement?	Yes	No
Has there been any change to your general health within the past year?	Yes	No	Have you had a serious illness or been hospitalized in the past 5 years?	Yes	No	Do you drink alcoholic beverages?	Yes	No
Do you use tobacco (smoking, snuff chew or vape)?	Yes	No	Are you wearing a nicotine patch?	Yes	No	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes explain	Yes	No
Dou have sleep Apnea	Yes	No	Have you ever taken FosaMax, Boniva, Actonel or other medications containing bisphosphonates?	Yes	No	Has a physician or previous dentist recommended you take antibiotics prior to your dental treatment?	Yes	No
Do your Gums Bleed when you brush or floss?	Yes	No	Are you currently experiencing Dental pain or discomfort	Yes	No	Are your teeth sensitive to Cold, Hot, sweets, or pressure?	Yes	No
Do you have ear aches or neck Pain?	Yes	No	Does food or floss catch between your teeth?	Yes	No	Do you have any clicking popping or discomfort in your jaw?	Yes	No

Medical and Dental History

Have you had any periodontal (gum) treatment?	Yes	No	Do you grind your teeth?	Yes	No	Have you ever had orthodontic (braces) treatment?	Yes	No
Do you have any sores or ulcers in your mouth?	Yes	No	Have you had any problems associated with previous dental treatment?	Yes	No	Is your home water supply fluoridated?	Yes	No
Do you wear partial dentures?	Yes	No	Do you wear dentures?	Yes	No	Have you ever had a serious injury to your head, neck or mouth?	Yes	No
Allergic Reactions								
ACE Inhibitors	Yes	No	Acetaminophen/Tylenol	Yes	No	Acrylic	Yes	No
Animals	Yes	No	Aspirin	Yes	No	Codeine	Yes	No
Demerol	Yes	No	Erythromycin	Yes	No	Hay fever/seasonal	Yes	No
Ibuprofen/Advil	Yes	No	Iodine	Yes	No	Latex	Yes	No
Local Anesthetic	Yes	No	Metals	Yes	No	Morphine	Yes	No
Penicillin	Yes	No	Seafood or Shellfish	Yes	No	Sulfa	Yes	No
Tetracycline	Yes	No						

1. Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please list: _____
2. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what? Physician's name _____
 Phone: If not, when was your last visit to your medical doctor? _____
3. Have you taken any medication or drugs during the past two years? Yes No

4. Are you taking any medication, drugs, or pills now? Yes No
If yes, please list name and dosage _____
5. Has a dentist or physician ever warned you against taking any drugs, etc. Yes No

6. Have you been a patient in the hospital in the past five years? Yes No
 years.....

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I notify the doctor of any change in my health or medication. Needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I notify the doctor of any change in my health or medication.

Patient/ Guardian Signature _____ Date _____

Comments

Doctor Signature _____ Date _____