

Patient Dental and Medical Health History Information

Dental History and Symptoms

What is the reason for your visit today?

Are you currently experiencing any dental **pain** or discomfort? Yes No If yes, where?

When was your last dental exam? ____/____/____ What was done at that appointment?

When was the last time you had dental x-rays taken?

Medical Information

Do you have any **allergies** to medications? Yes No If so what:

Please list all **medications**, vitamins or supplements you are currently taking:

Name of **PCP (family doctor)**: _____ Date of last visit: _____

Has a physician or dentist recommended that you take **antibiotics** prior to dental work? Yes No

If so for what? _____ For how long? _____

Have you ever taken any **bone density medications** (eg: Fosamax, Alendronate, Boniva, Altiva, Actonel, Reclast, Zometa, Xgeva or Prolia)? Yes No

Are you taking any **blood thinners** (eg: Coumadin, Xarelto, Warfarin, Plavix, heparin or Aspirin?) Yes No

Have you ever been treated for **cancer**? Yes No When? _____ If applicable: radiation chemotherapy

Have you ever had a **heart valve replacement** or heart surgery? Yes No

Have you had a **serious illness, operation or been hospitalized in the last 5 years**? Yes No

Women Only: Are you currently pregnant? Yes No # weeks _____ Are you currently nursing? Yes No

Do you use tobacco? Yes No Do you vape? Yes No How many alcoholic beverages per week? _____

Do you or have you used controlled substances (drugs, including marijuana)? Yes No

If yes, What substances? _____ How often do you use? _____

Medical History Specific: Checkmark if Applicable

- Heart**
- Pacemaker/ Implanted defibrillator
- Artificial Heart Valve
- Previous Infective Endocarditis
- Congenital Heart Disease
- Damaged Heart Valves
- Angina
- Congestive Heart Failure
- Heart Murmur
- Heart Attack
- Rheumatic Heart Disease
- Stroke
- Breathing (Respiratory) Health**
- Asthma
- COPD
- Tuberculosis
- Sinus Trouble

- Sleep Apnea
- Cancer**
- Type: _____
- Year of Diagnosis: _____
- Chemo: _____
- Radiation: _____

- Blood (Circulatory) Health**
- Anemia
- Hemophilia
- High Blood Pressure
- Low Blood Pressure
- Brain (neurological) Health**
- Anxiety
- Depression
- Epilepsy
- Mental Health Disorders

- Other**
- Glaucoma
- Diabetes (type 1 or 2)
- Eating Disorder
- Frequent Infections
- Hepatitis, jaundice or liver disease
- Immune Deficiency
- Kidney Problems
- Organ Transplant
- Osteoporosis
- Sexually Transmitted Infection (STI)
- Thyroid Problems
- Drug Addiction Traumatic brain injury
- Gastrointestinal disease
- G.E. Reflux/ Heartburn (GERD)
- Stomach Ulcers

Do you have any disease, condition or relevant problem that's not listed here? If so please explain:

I authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read and agree to the above terms and conditions. Yes No

I have answered ALL questions/alerts accurately. I am aware I must notify the practice of any future changes.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: _____ **Date:** _____

For completion by the staff

Reviewed by: _____ **Date:** _____