Medical and Dental History Form

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical Information

Are you under a physician's care now? List provider: ◯ Yes ◯ No If yes

Please rate your overall health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical exam: ◯ Yes ◯ No If yes

Have there been any health changes in the past year? Please describe: ◯ Yes ◯ No If yes

Have you had a serious illness, operation or been hospitalized in the past 5 years? Please describe: ◯ Yes ◯ No If yes

Have you ever had a serious head or neck injury? Please describe: ◯ Yes ◯ No If yes

List all PRESCRIPTION medications, pills, or drugs (name/dose/amount): ◯ Yes ◯ No If yes

List all OVER-THE-COUNTER medications, pills or drugs (name/dose/amount): ◯ Yes ◯ No If yes

Do you take any vitamins or natural supplements? Please list: ◯ Yes ◯ No If yes

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No If yes

Do you currently take medications that thin your blood, such as (check all that apply):

☐ Warfarin (Coumadin) ☐ Eliquis ☐ Xarelto ☐ Pradaxa
☐ Effient ☐ Other

If yes to any of the above, indicate your most recent INR/PT value: ◯ Yes ◯ No If yes

Do you currently take a daily aspirin? If yes, please list amount and frequency: ◯ Yes ◯ No If yes

Are you on a special diet? If yes, please describe: ◯ Yes ◯ No If yes

Bisphosphonate Therapy

Are you currently, or have you ever, taken oral bisphosphonates such as those listed below or any other medications for osteoporosis or Paget's disease?

☐ Aledronate (Fosamax) ☐ Ibandronate (Boniva) ☐ Risedronate (Actonel) ☐ Zoledronic acid (Reclast)
☐ Other

If yes to above question, please list (name/dose/amount/start date): ◯ Yes ◯ No If yes

Have you or are you scheduled to be treated with IV bisphosphonates (Aredia or Zometa) for:

☐ Paget's disease of bone ☐ Multiple myeloma ☐ Metastatic cancer

If yes, list date treatment began: ◯ Yes ◯ No If yes

Substance Use

Do you use tobacco?

- [ ] Cigarettes
- [ ] Cigars
- [ ] Pipe
- [ ] Smokeless tobacco/dip
- [ ] E-Cigarettes/vape

If you are a tobacco user, are you interested in quitting?

- [ ] Very interested
- [ ] Somewhat interesterd
- [ ] Not at all interested

If you are a tobacco user, how many packs per day?	○ Yes ○ No	If yes	
Do you drink alcoholic beverages?	○ Yes ○ No		
If you drink alcohol, how many drinks per week?	○ Yes ○ No	If yes	
Do you use controlled substances? If yes, describe:	○ Yes ○ No	If yes	
Do you have a history of substance abuse or drug addiction? If yes, please describe:	○ Yes ○ No	If yes	

Women Only

Please indicate if you are:

- [ ] Pregnant
- [ ] Trying to get pregnant
- [ ] Nursing
- [ ] Taking oral contraceptive
- [ ] None

Allergies

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Acrylic
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics
- [ ] Codeine

If answered yes to any of the above, please describe your reaction:	○ Yes ○ No	If yes	

Pre-Med Conditions

Do you have, or have you ever had, any of the following diseases or problems:

- [ ] Artificial (prosthetic) heart valve
- [ ] Previous infective endocarditis
- [ ] Damaged valves in transplanted heart
- [ ] Congenital heart disease (CHD)

If yes to Congential Heart Disease (CHD), mark all that apply:

- [ ] Unrepaired, cyanotic CHD
- [ ] Repaired (completely) in last 6 months
- [ ] Repaired CHD w/ residual defects

Do you have an artificial joint? If yes, please describe and list date:	○ Yes ○ No	If yes	
Has a physician or dentist ever recommended you take antibiotics prior to dental treatment?	○ Yes ○ No	If yes	

Medical Conditions

Do you currently, or have you in the past, had any of the following:

Cardiovascular disease	Yes	No	Systemic lupus erythematous	Yes	No	Hepatitis A	Yes	No
Angina/chest pain	Yes	No	Dermatologic condition	Yes	No	Hepatitis B or C	Yes	No
Arrhythmia/irregular heartbeat	Yes	No	Asthma	Yes	No	Liver disease	Yes	No
Arteriosclerosis	Yes	No	Bronchitis	Yes	No	Yellow jaundice	Yes	No
Congestive heart failure (CHF)	Yes	No	COPD	Yes	No	Kidney problems	Yes	No
Damaged heart valves	Yes	No	Easily winded	Yes	No	Renal dialysis	Yes	No
Heart attack	Yes	No	Emphysema	Yes	No	Epilepsy/seizures	Yes	No
Heart murmur	Yes	No	Tuberculosis	Yes	No	Fainting or dizziness	Yes	No
Other congential heart defects	Yes	No	Cancer	Yes	No	Neurological disorder	Yes	No
Mitral valve prolapse	Yes	No	Leukemia	Yes	No	Chronic pain/fibromyalgia	Yes	No
Heart pacemaker	Yes	No	Tumors or growths	Yes	No	Mental health disorder	Yes	No
High blood pressure	Yes	No	Chemotherapy treatment	Yes	No	Depression	Yes	No
Low blood pressure	Yes	No	Radiation treatment	Yes	No	Alzheimer's disease/dementia	Yes	No
High cholesterol	Yes	No	Diabetes Type I	Yes	No	Severe headaches/migraines	Yes	No
Stroke	Yes	No	Diabetes Type II	Yes	No	Anaphylaxis	Yes	No
Rheumatic fever	Yes	No	Hypoglycemia	Yes	No	Sexually transmitted disease	Yes	No
Rheumatic heart disease	Yes	No	Pancreatic disease	Yes	No	Glaucoma	Yes	No
Abnormal bleeding	Yes	No	Artificial joint	Yes	No	Recurrent infections	Yes	No
Excessive bleeding	Yes	No	Osteoporosis	Yes	No	Scarlet fever	Yes	No
Hemophilia	Yes	No	Pain in jaw joints	Yes	No	Hay fever	Yes	No
Anemia	Yes	No	Spina bifida	Yes	No	Seasonal allergies	Yes	No
Low iron levels	Yes	No	Eating disorder	Yes	No	Shingles	Yes	No
Blood transfusion	Yes	No	Gastrointestinal disease	Yes	No	Cold sores/fever blisters	Yes	No
AIDS/HIV+	Yes	No	GI reflux/persistent heartburn	Yes	No	Persistent swollen glands in neck	Yes	No
Arthritis	Yes	No	Ulcers	Yes	No	Tonsillitis	Yes	No
Autoimmune disease	Yes	No	Hyperthyroid	Yes	No	Severe or rapid weight loss	Yes	No
Gout	Yes	No	Hypothyroid	Yes	No	Excessive thirst or urination	Yes	No
Rheumatoid arthritis	Yes	No	Parathyroid disease	Yes	No	Immunosuppression	Yes	No
Cortisone medication	Yes	No						

Have you ever had any serious illness not listed above? If yes, please describe: Yes No If yes

Diabetic Patients Only

Most recent A1c or blood glucose level:

Cancer Patients Only

Type of cancer:

Date of diagnosis:

Treatment:

AIDS/HIV+ Patients Only

Most recent CD4+ count:

Most recent viral load count:

Hepatitis Patients Only

Type of Hepatitis:

Date of diagnosis:

Treatment:

Dental Information

Do your gums bleed when you brush or floss? ○ Yes ○ No

Teeth sensitive to hot, cold, sweets or pressure? ○ Yes ○ No

Does food or floss catch between your teeth? ○ Yes ○ No

Is your mouth dry? ○ Yes ○ No

Have you had any periodontal (gum) treatments? ○ Yes ○ No

Have you ever had orthodontic (braces) treatment? ○ Yes ○ No

Is your home water supply fluoridated? ○ Yes ○ No

Do you drink bottled or filtered water?

☐ Daily ☐ Weekly ☐ Occasionally

Are you currently experiencing dental pain? ○ Yes ○ No

Do you have earaches or neck pain? ○ Yes ○ No

Clicking, popping or discomfort in the jaw? ○ Yes ○ No

Do you brux or grind your teeth? ○ Yes ○ No

Do you have sores or ulcers in your mouth? ○ Yes ○ No

Do you wear partials or dentures? ○ Yes ○ No

Serious injury to your head or mouth? ○ Yes ○ No

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays?

What is the reason for your dental visit today?

How do you feel about your smile?

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____