Medical History (12/12/23)

Medical history

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.

Primary Physician

Are you currently under the care of physician? *

Yes No

Current Physician name and contact information: *

Yes No

Have you ever been hospitalized or had a major operation? Please list with approximate dates: *

Yes No

Have you ever had a serious head or neck injury? *

Yes No

Are you taking any medications, pills, drugs, or vitamins/supplements? If yes Please list: *

Yes No

Have you ever taken Fosamax/Alendronate, Prolia, Boniva or any other medications for osteoporosis? If yes, When: *

Yes No

Are you on a special diet? If yes, please list. *

Yes No

Do you use controlled substances? *

Yes No

Do you have sleep apnea and use a CPAP *

Yes No

Dental history

When was your last dental visit? aprox month/year *

Yes No

Are you happy with the appearance of your smile? *

Yes No

Do you have pain in any of your teeth? *

Yes No

Have you noticed any teeth loosening? *

Yes No

Do you clench or grind your teeth? *

Yes No

Do you have pain in your jaw joints, TMJ? *

Yes No

Have you had orthodontics? *

Yes No

Do you suffer from dry mouth (xerostomia)? *

○ Yes ○ No

Tobacco Use

Do you use Tobacco?

Chewing/snuff * ○ Yes ○ No

Smoking * ○ Yes ○ No

Vaping * ○ Yes ○ No

Do you regularly use Marijuana?

CBD * ○ Yes ○ No

Edibles * ○ Yes ○ No

Smoking * ○ Yes ○ No

Vaping * ○ Yes ○ No

Women: Are you...

☐ Nursing? ☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Penicillin ☐ Sulfa Drugs

Other allergies? Please list: * ○ Yes ○ No

Do you have, or have you had, any of the following?

AIDS/HIV Positive * ○ Yes ○ No

Alzheimer's Disease * ○ Yes ○ No

Anaphylaxis * ○ Yes ○ No

Anemia * ○ Yes ○ No

Angina * ○ Yes ○ No

Arthritis/Gout * ○ Yes ○ No

Artificial Heart Valve * ○ Yes ○ No

Artificial Joint * ○ Yes ○ No

Asthma * ○ Yes ○ No

Blood Disease * ○ Yes ○ No

Blood Transfusion * ○ Yes ○ No

Breathing Problems * ○ Yes ○ No

Bruise Easily * ○ Yes ○ No

Cancer * ○ Yes ○ No

Chemotherapy * ○ Yes ○ No

Chest Pains * ○ Yes ○ No

Cold Sores/Fever Blisters * ○ Yes ○ No

Congenital Heart Disorder * ○ Yes ○ No

Cortisone Medicine * ○ Yes ○ No

Diabetes * ○ Yes ○ No

Drug Addiction * ○ Yes ○ No

Easily Winded * ○ Yes ○ No

Emphysema * ○ Yes ○ No

Epilepsy or Seizures * ○ Yes ○ No

Excessive Bleeding * ○ Yes ○ No

Excessive Thirst * ○ Yes ○ No

Fainting Spells/Dizziness * ○ Yes ○ No

Frequent Cough * ○ Yes ○ No

Frequent Diarrhea * ○ Yes ○ No

Frequent Headaches * ○ Yes ○ No

Genital Herpes * ○ Yes ○ No

GERD/acid reflux * ○ Yes ○ No

Glaucoma * ○ Yes ○ No

Heart Attack/Failure * ○ Yes ○ No

Heart Murmur * ○ Yes ○ No

Heart Pacemaker * ○ Yes ○ No

Heart Stent Surgery * ○ Yes ○ No

Heart Trouble/Disease * ○ Yes ○ No

Hemophilia * ○ Yes ○ No

Hepatitis A * ○ Yes ○ No

Hepatitis B or C * ○ Yes ○ No

Herpes * ○ Yes ○ No

High Blood Pressure * ○ Yes ○ No

High Cholesterol * ○ Yes ○ No

Hives or Rash * ○ Yes ○ No

Hypoglycemia * ○ Yes ○ No

Irregular Heartbeat * ○ Yes ○ No

Kidney Problems * ○ Yes ○ No

Leukemia *
○ Yes ○ No

Liver Disease *
○ Yes ○ No

Low Blood Pressure *
○ Yes ○ No

Lung Disease *
○ Yes ○ No

Mitral Valve Prolapse *
○ Yes ○ No

Osteoporosis *
○ Yes ○ No

Parathyroid Disease *
○ Yes ○ No

Psychiatric Care *
○ Yes ○ No

Radiation Treatments *
○ Yes ○ No

Recent Weight Loss *
○ Yes ○ No

Renal Dialysis *
○ Yes ○ No

Rheumatic Fever *
○ Yes ○ No

Rheumatism *
○ Yes ○ No

Scarlet Fever *
○ Yes ○ No

Shingles *
○ Yes ○ No

Sickle Cell Disease *
○ Yes ○ No

Sinus Trouble *
○ Yes ○ No

Spina Bifida *
○ Yes ○ No

Stomach/Intestinal Disease *
○ Yes ○ No

Stroke/TIA *
○ Yes ○ No

Swelling of Limbs *
○ Yes ○ No

Thyroid Disease *
○ Yes ○ No

Tonsillitis *
○ Yes ○ No

Tuberculosis *
○ Yes ○ No

Tumors or Growths *
○ Yes ○ No

Ulcers *
○ Yes ○ No

Venereal Disease *
○ Yes ○ No

Yellow Jaundice *
○ Yes ○ No

Have you ever had any serious illness not listed above? *
○ Yes ○ No

Additional comment

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.

Sign Here

Signature *