Dental MedicalHistory

Name: _____Preferred Name:_____Pronouns: _____

CHECK THE APPROPRIATE ANSWER

1. Purpose of visit: _____
2. How long has it been since your last dental treatment: _____
3. Are any of your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure? If so, which teeth? _____
4. Are you experiencing any pain or discomfort at this time? ☐ YES ☐ NO
5. Have you ever had gum treatment or gum surgery? ☐ YES ☐ NO
6. Do your gums bleed or hurt? ☐ YES ☐ NO
7. Do you have any sores or lumps in or near your mouth? ☐ YES ☐ NO
8. Does your jaw pop or click? ☐ YES ☐ NO
9. Do you often have headaches, neck aches or shoulder aches? ☐ YES ☐ NO
   What time of day? ☐ Morning ☐ Night
10. Have you experienced pain or difficulty when chewing? ☐ YES ☐ NO
11. Have you experienced difficulty in opening and closing? ☐ YES ☐ NO
12. Do you clench or grind your teeth (while awake or asleep)? ☐ YES ☐ NO
13. Are you happy with the appearance of your teeth? ☐ YES ☐ NO
14. Have you ever had any problems or complications with previous dental treatment? ☐ YES ☐ NO
15. How often do you brush and floss your teeth? _____
16. Physician's (or medical clinic's) name? _____
17. When was your last physical exam? _____
19. Are you under the care of a physician? ☐ YES ☐ NO
    Since when?_____Why? _____
20. Has there been any change in your general health within the past year? ☐ YES ☐ NO
21. Have you ever had a serious illness or major surgery? ☐ YES ☐ NO
    if so, explain: _____
22. Are you allergic or have sensitivities to any medications or substances? ☐ YES ☐ NO
    if so, explain: _____
23. Do you have other allergies or sensitivities? ☐ YES ☐ NO
24. Have you ever had any problems with (or adverse reactions to) penicillin or other antibiotics, sulfa drugs, Anesthetics, or other medications? ☐ YES ☐ NO
25. Are you sensitive to any metals, latex or other materials? ☐ YES ☐ NO
26. Are you taking medications? (Include antibiotics) ☐ YES ☐ NO
    Please list & Explain: _____
    _____
27. Are you taking any over the counter medications and/or supplements? ☐ YES ☐ NO
    Please list: _____
28. Have you ever taken any prescription weight loss medications? ☐ YES ☐ NO

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Dental Medical History (continued)

29. Are you taking any bisphosphonate medications (i.e. Fosamax, Boniva)? ☐ YES ☐ NO
30. Are you being or have you been treated for chemical dependency? ☐ YES ☐ NO
31. Do you smoke, chew, use snuff or any other forms of tobacco? ☐ YES ☐ NO
32. Are you pregnant or do you suspect you may be? ☐ YES ☐ NO

    How many weeks / due date: _____

33. Have you had or do you test positive for hepatitis? ☐ YES ☐ NO
34. Have you tested H.I.V. positive? ☐ YES ☐ NO
35. Have you ever been treated or been told that you might have a heart condition, heart disease or a heart murmur? ☐ YES ☐ NO
36. Do you have a pacemaker, artificial heart valve implant, artificial joints, implants, or prosthesis? ☐ YES ☐ NO
37. Do you have or have you ever had any of the following diseases, or conditions? If you answer yes, please indicate when.

    a. Prolapsed mitral valve? ☐ YES ☐ NO _____
    b. High or low blood pressure? ☐ YES ☐ NO _____
    c. Stroke? ☐ YES ☐ NO _____
    d. Asthma or sinus trouble? ☐ YES ☐ NO _____
    e. Tuberculosis (T.B.)? ☐ YES ☐ NO _____
    f. Epilepsy or seizure disorder? ☐ YES ☐ NO _____
    g. Diabetes? ☐ YES ☐ NO _____
    h. Thyroid problems? ☐ YES ☐ NO _____
    I. Stomach ulcers? ☐ YES ☐ NO _____
    j. Eating disorders? ☐ YES ☐ NO _____
    k. Kidney trouble, transplant or dialysis? ☐ YES ☐ NO _____
    I. Liver disease or jaundice ☐ YES ☐ NO _____
    m. Rheumatic fever, scarlet fever, or rheumatic heart disease? ☐ YES ☐ NO _____
    n. Inflammatory diseases (arthritis, rheumatism)? ☐ YES ☐ NO _____
    o. Any sexually transmitted disease? ☐ YES ☐ NO _____
    p. If you are 26 years old or younger have you completed the HPV series? ☐ YES ☐ NO _____
    q. Bled excessively after being cut or injured? ☐ YES ☐ NO _____
    r. Any blood disorders (anemia, leukemia, etc.)? ☐ YES ☐ NO _____

38. Is there anything else we should know about your health that we have not covered in this form? ☐ YES ☐ NO

_____

_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's signature: _____ Date: _____

Provider's signature: _____ Date: _____

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