

MEDICAL-DENTAL HISTORY

Name (Dr., Mr., Ms., Mrs.): _____

Employer: _____

What should we call you? _____

Occupation: _____

Date of birth: _____

Dental Insurance: Yes No

Address: _____

Social Security Number: _____

City: _____ Zip Code: _____

Dentist: _____

Home Phone: _____

(Name) (Phone Number)

Family Physician: _____

Cell Phone: _____

(Name) (Phone Number)

Cardiologist: _____

Work Phone: _____

(Name) (Phone Number)

Pain Management: _____

Email Address: _____

(Name) (Phone Number)

Other Physician: _____

Referred by: _____

(Name) (Phone Number)

Other Physician: _____

(Name) (Phone Number)

Emergency Contact: _____
(Name) (Phone Number)

Pharmacy: _____
(Name) (Phone Number) (Address)

Height & Weight: _____
(Necessary for prescribing RX)

1. Are you currently under the care of a physician? Yes No

2. Please list dates and reasons for hospitalizations _____

3. Please list allergies to drugs or medications _____

Have you ever been treated for the following conditions:

4. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? If yes, please specify. _____

5. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? If yes, please specify. _____

Have you ever or are you currently been treated for the following conditions:

6. Excessive bleeding: Yes No List medications: _____

7. Breathing problems, asthma, tuberculosis, hay fever: Yes No List medications: _____

8. Thyroid disease or trouble: Yes No List medications: _____

9. Cancer, x-ray treatment, or chemotherapy: Yes No List medications: _____

10. Hepatitis, jaundice, or liver disease: Yes No List medications: _____

11. Kidney problems or renal dialysis: Yes No List medications: _____

12. STD's or HIV: Yes No List medications: _____

13. A stroke, convulsions, or fainting spells: Yes No List medications: _____

14. Tumors or growths: Yes No List medications: _____

15. Arthritis or rheumatism: Yes No List medications: _____

16. High cholesterol: Yes No List medications: _____

17. High blood pressure: Yes No List medications: _____

18. Diabetes: Yes No List medications: _____

If yes: Type 1 Type 2 When was your last AIC test result: _____ How often are you tested: _____

Do you take any of the following:

19. Pain medications: Yes No List medications: _____

20. Anxiety or mind altering medications: Yes No List medications: _____

21. Sleep medications: Yes No List medications: _____

22. Osteoporosis medications: Yes No List medications: _____

23. Aspirin and/or blood thinners: Yes No If yes, dose: _____

24. Vitamin or herbal supplements: Yes No List medications: _____

25. Please list any other medications you are taking and for what reason: _____

26. Weight-loss supplements(prescription and/or over-the-counter): Yes No List medications: _____

27. Have you ever had a serious injury to your head or neck? If yes, describe. _____

28. Do you smoke? Yes No If yes, describe type and frequency: _____

29. For women: Are you pregnant or breastfeeding? _____

DENTAL HISTORY

30. What would you like done for your mouth? _____

31. Are you satisfied with the appearance of your teeth? _____

32. Are you satisfied with your ability to chew? _____

33. Does food catch between your teeth: Yes No

34. Are any of your teeth sensitive to heat, cold, or pressure: Yes No

35. Do you snore: Yes No

36. Have you been diagnosed with sleep apnea: Yes No

37. Do you get headaches or migraines: Yes No

38. Do you grind your teeth or clench your jaws: Yes No

39. Do you have pain or clicking in the jaw joint around your ear: Yes No

40. Have your jaw muscles ever been sore: Yes No If yes, please describe _____

41. Are there any sores or growths in your mouth: Yes No

42. Do any of your teeth ache: Yes No

43. How often do you have your teeth cleaned? _____ Date of last cleaning: _____

In respect to previous dental treatment have you:

44. Ever had a bad dental experience: Yes No

45. Had an allergic reaction: Yes No If yes, please describe: _____

46. Had abnormal bleeding: Yes No

47. Other complications during or following dental treatment: Yes No If yes, please describe: _____

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the above questions have been accurately answered.

Permission to release health information:

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment, to third party payors and/or health care practitioners.

Person completing this form:

Signature Printed Name Date

If other than patient, indicate relationship: _____