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Medical History

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Are you now under the care of a physician? * ◯ Yes ◯ No

Physician's name, address and phone number:

_____

_____

What is your estimate of your general health? *

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has there been any change in your general health within the past year? * ◯ Yes ◯ No

If yes, please explain:

_____

_____

Date of last physical exam: _____

Have you had any serious illnesses, or have been hospitalized in the last 5 years? If yes please explain

_____

_____

Pharmacy Name and Phone Number

_____

_____

Are you taking or have recently taken prescription or over the counter medication? * ◯ Yes ◯ No

If so, please list all including vitamins, herbal, natural and or dietary supplements

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

Do you have any of the following diseases or problems?

Active Tuberculosis * ◯ Yes ◯ No

Persistent cough greater than a 3 week duration * ◯ Yes ◯ No

Cough that produces blood * ◯ Yes ◯ No

Been exposed to anyone with tuberculosis * ◯ Yes ◯ No

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Do you have any of the following conditions? * ◯ Yes ◯ No

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Abnormal bleeding
- ☐ Allergy- Animals
- ☐ Allergy to Ibuprofen
- ☐ Allergy-Animals
- ☐ Allergy-Food
- ☐ Allergy-Local Anesth
- ☐ Allergy-Seasonal
- ☐ Anemia
- ☐ Artificial joints
- ☐ Autoimmune
- ☐ Blood pressure-Low
- ☐ Cancer
- ☐ Chest pain
- ☐ Congestive heart
- ☐ Deaf in one ear
- ☐ Diabetes-Type I
- ☐ Epi sensitivity
- ☐ Fainting
- ☐ Hashimotos
- ☐ Heart defects
- ☐ Hemophilia
- ☐ Hyperthyroid
- ☐ Jaundice
- ☐ Lactose Intolerance
- ☐ Menopause
- ☐ Naproxin
- ☐ Nickel
- ☐ Other
- ☐ Radiation treatment
- ☐ Respiratory problems
- ☐ Rheumatoidarthristis
- ☐ STD's
- ☐ Tuberculosis
- ☐ Acid Reflux
- ☐ Allergy- Metranizole
- ☐ Allergy-ACE Inhibit
- ☐ Allergy-Aspirin
- ☐ Allergy-Hay Fever
- ☐ Allergy-Metals
- ☐ Allergy-Sedatives
- ☐ Angina
- ☐ Asthma
- ☐ Bioxin
- ☐ Blood transfusion
- ☐ Cardiovascular
- ☐ Chronic pain
- ☐ Darvan
- ☐ Dental Fear-N20
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fenergan
- ☐ Head injuries
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Hypothyroidism
- ☐ Keflax
- ☐ Liver disease
- ☐ Mental disorders
- ☐ Nervous disorders
- ☐ Night sweats
- ☐ Pre-Med-Amox
- ☐ Recurrent infections
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Stroke
- ☐ Tumors
- ☐ Allergy - Gluten
- ☐ Allergy- Milk
- ☐ Allergy-Amlodipine
- ☐ Allergy-Barbiturates
- ☐ Allergy-Iodine
- ☐ Allergy-Other
- ☐ Allergy-Vicodin
- ☐ Arteriosclerosis
- ☐ Atrial Fibrillation
- ☐ Blood Disease
- ☐ Blood-Hemophilia
- ☐ Carpal tunnel
- ☐ Cipro
- ☐ Darvicent
- ☐ Diabetes-Type II
- ☐ Eating disorder
- ☐ Excessive Bleeding
- ☐ Gastrointestinal
- ☐ Headaches
- ☐ Heart-MVP
- ☐ High cholesterol
- ☐ Ibuprofen
- ☐ Kidney disease
- ☐ Lupus
- ☐ Migraines
- ☐ Neurological problem
- ☐ NO EPI - hx of Rxn
- ☐ Pre-Med-Other
- ☐ Reflux/GERD
- ☐ Rheumatic heart
- ☐ Sinus problems
- ☐ Swollen neck glands
- ☐ Ulcers
- ☐ Allergy- Ampicillian
- ☐ Allergy Peanuts
- ☐ Allergy-Amox
- ☐ Allergy-Codeine
- ☐ Allergy-Latex
- ☐ Allergy-Penicillin
- ☐ Allergy-Zithromax
- ☐ Arthritis
- ☐ Augmentin
- ☐ Blood Pressure-High
- ☐ Bronchitis
- ☐ Chemotherapy
- ☐ Compazine
- ☐ Deaf
- ☐ Diabetes-Type III
- ☐ Emphysema
- ☐ Excessive unrination
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart-Pacemaker
- ☐ HIV/AIDS
- ☐ Insomnia
- ☐ Kidney problems
- ☐ Malnutrition
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ Reglan
- ☐ Rheumatism
- ☐ Sleep apnea
- ☐ Thyroid problem
- ☐ Weight loss-severe

- ☐ Recent hospitalization (illness or injury)
- ☐ Tobacco Use- Smoke, Vape or Chew
- ☐ Chemical Dependency
- ☐ Presently being treated for any other illnesses/conditions
- ☐ Alcohol Dependancy

Any other allergies or health concerns not listed: * ◯ Yes ◯ No

Other allergies/health concerns:

_____

_____

Tobacco Use - How interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? * ◯ Yes ◯ No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

_____

Women Only:

Please select all the apply:

☐ Currently Pregnant ☐ Currently Nursing ☐ Currently taking Birth Control ☐ Trying to get pregnant(Invitro)

☐ Hormone Replacement Therapy

Bone Density Treatment

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? If yes treatment began

_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax?) or risedronate (Actonel?) for osteoporosis or Paget's disease? *

◯ Yes ◯ No

Are you required to take a premedication before dental treatment? * ◯ Yes ◯ No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? * ◯ Yes ◯ No

Are you required to take a premedication before dental treatment? * ◯ Yes ◯ No

Type of premedication: _____

Name of orthopedic surgeon and phone number:

_____

_____

Please explain your need to premedicate:

_____

_____

_____

Please check all that apply:

☐ Artificial (prosthetic) heart valve ☐ Previous infective endocarditis ☐ Damaged valves in transplanted heart

☐ Congenital heart disease (CHD) ☐ Unrepaired, cyanotic CHD ☐ Repaired (completely) in last 6 months

☐ Repaired CHD with residual defects

Are you required to take a premedication before dental treatment? * ◯ Yes ◯ No

Type of premedication: _____

Name of cardiologist and phone number:

_____

_____

Please explain your need to premedicate:

_____

_____

Dental History

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays: What was done at that time?

_____

_____

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is the reason for your dental visit today?

_____

_____

Do you participate in active recreational activities? * ◯ Yes ◯ No

Do you wear a nightguard? * ◯ Yes ◯ No

Do you wear a retainer? * ◯ Yes ◯ No

Please indicate which arch for retainer:

☐ Upper ☐ Lower ☐ Both

Please check all that apply:

☐ Gums bleed when you brush or floss
☐ Bad mouth odor
☐ Have broken fillings
☐ Teeth sensitive to cold, hot, sweets or pressure
☐ Periodontal(gum) treatment
☐ Had any problems associated with previous dental treatment
☐ Currently experiencing dental pain or discomfort
☐ Have any clicking, popping, or discomfort in the jaw
☐ Have/had sores or ulcers in your mouth
☐ Have/had a serious injury to your head or mouth
☐ Food gets trapped in spaces
☐ Have/had loose teeth
☐ Missing teeth
☐ Experience Dry Mouth
☐ Orthodontic treatment(braces)
☐ Drink bottled or filtered water
☐ Have/had earaches, or neck pain
☐ Brux or grind your teeth
☐ Wear dentures or partials

Smile Evaluation

Do you like the way your teeth look? * ◯ Yes ◯ No

Would you like for your teeth to be whiter? * ◯ Yes ◯ No

Would you like your teeth to be straighter? * ◯ Yes ◯ No

Explain:

_____

_____

Do you have missing teeth that you would like to replace? * ◯ Yes ◯ No

Explain:

_____

_____

Do you have old silver fillings that you would like to replace with tooth-colored fillings? * ◯ Yes ◯ No

Explain:

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Sleep Apnea Questionnaire:

Please check all that apply:

- ☐ Currently use CPAP?
- ☐ Snoring - Do you Snore Loudly (loud enough to be heard through closed doors or you bed-partner elbow you for snoring at night)?
- ☐ Tired - Do you often feel Tired, Ftigued, or Sleepy during the daytime (such as falling asleep during driving)?
- ☐ Observed - Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep?
- ☐ Pressure - Do you have or are you being treated for High Blood Pressure?
- ☐ Age - Older than 50?
- ☐ Neck Size - (Measure around Adams apple) Male is your shirt collar 17' or larger? Female is your collar 16" of larger?
- ☐ Gender = Male?

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: _____