PATIENT MEDICAL & DENTAL HISTORY

PATIENT NAME: _____ **DOB:** _____ **Date:** _____

Previous hospitalizations / surgeries

Current medications

Allergies

Other medical concerns

Previous Dentist's name

What is the reason for your visit today?

Do you have any dental problems now?
If yes, please describe

Do you feel nervous about having dental treatment? if yes, what is your biggest concern?

Have you ever had an upsetting dental experience? If yes, please describe

Who may we thank for referring you to our office?

PATIENT MEDICAL & DENTAL HISTORY

DENTAL HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	Bad Breath	☐	☐	Food collection in teeth	☐	☐	Mouth pain
☐	☐	Bleeding Gums	☐	☐	Foreign objects in mouth	☐	☐	Orthodontics
☐	☐	Blisters (mouth or lips)	☐	☐	Grinding teeth	☐	☐	Pain around ear
☐	☐	Burning Sensation	☐	☐	Gums swollen/tender	☐	☐	Periodontal treatment
☐	☐	Chewing on one side	☐	☐	Jaw pain/tiredness	☐	☐	Sensitivity to cold
☐	☐	Clicking or Popping Jaw	☐	☐	Lip or cheek biting	☐	☐	Sensitivity to heat
☐	☐	Dry Mouth	☐	☐	Loose teeth / broken fillings	☐	☐	Sensitivity to sweets
☐	☐	Fingernail biting	☐	☐	Mouth breathing	☐	☐	Other

_____ Date of last dental visit?

_____ Date of last full mouth x-rays?

_____ Date of last dental cleaning?

_____ How often do you have dental examinations?

_____ How often do you brush/floss?

_____ What other dental aids do you use?

MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Head Injury	☐	☐	Rheumatic heart disease
☐	☐	AIDS/HIV Infection	☐	☐	Heart Attack	☐	☐	Rheumatoid arthritis
☐	☐	Anemia	☐	☐	Heart Problems or Disease	☐	☐	Scarlet Fever
☐	☐	Angina	☐	☐	Heart murmur	☐	☐	Scarring / Keloids
☐	☐	Arthritis, Rheumatism	☐	☐	Hemophilia	☐	☐	Severe headaches/ migraines
☐	☐	Asthma	☐	☐	Hepatitis – type:	☐	☐	Seizures / Convulsions
☐	☐	Autoimmune disease	☐	☐	Herpes	☐	☐	Shortness of Breath
☐	☐	Back Problems	☐	☐	High Blood Pressure	☐	☐	Sinus Trouble
☐	☐	Blood transfusion If yes, date: _____	☐	☐	HIV Positive	☐	☐	Skin Rash
☐	☐	Bronchitis	☐	☐	Jaundice	☐	☐	Sleep disorder
☐	☐	Cancer	☐	☐	Jaw Pain	☐	☐	Do you snore?
☐	☐	Carotid Artery Disease	☐	☐		☐	☐	Special Diet / Weight Loss
☐	☐	Chemical Dependency	☐	☐	Kidney Disease	☐	☐	Spinal Injury
☐	☐	Chemotherapy	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Chronic Pain	☐	☐	Low Blood Pressure	☐	☐	Swollen Feet or Ankles

PATIENT MEDICAL & DENTAL HISTORY

☐	☐ Circulatory Problems	☐	☐ Lung Disease	☐	☐ Swollen Neck Glands
☐	☐ Congestive Heart Failure	☐	☐ Mental Health disorders Specify: _____	☐	☐ Systemic lupus erythematosus
☐	☐ Cortisone Treatments	☐	☐ Migraines	☐	☐ Temporal Arteritis
☐	☐ Cough	☐	☐ Mitral valve prolapse		
☐	☐ Damaged heart valves	☐	☐ Nervous Problems	☐	☐ Thyroid Problems
☐	☐ Diabetes	☐	☐ Neurological Disease		
☐	☐ Eating disorder	☐	☐ Osteoporosis	☐	☐ Tonsillitis
☐	☐ Emphysema	☐	☐ Pacemaker	☐	☐ Tuberculosis
☐	☐ Epilepsy	☐	☐ Prostate Disorder	☐	☐ Tumors or Growths
☐	☐ Fainting or Dizziness	☐	☐ Psychiatric Disorder or Care	☐	☐ Ulcers
☐	☐ Gastrointestinal Disease	☐	☐ Recurrent Infections	☐	☐ Venereal Disease
☐	☐ G.E. Reflux/persistent heartburn	☐	☐ Rheumatic fever	☐	☐ Other
☐	☐ Glaucoma	☐	☐ Radiation Treatment		
☐	☐ Headaches	☐	☐ Respiratory Disease		

Yes	No	
☐	☐	Are you taking or scheduled to begin taking an antiresporative agent (like Fosamax*, Actonel*, Boniva*, Reclast, Prolia) for osteoporosis or Paget's disease?
☐	☐	Since 2001, were you treated or are you presently scheduled to being treatment with an antiresporptive agent (like Aredia*, Zometa*, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
☐	☐	Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ If yes, have you had any complications?

ADDITIONAL QUESTIONS

Yes	No	
☐	☐	Do you drink? # per day _____
☐	☐	Do you smoke? # per day _____
☐	☐	Do you vape? ☐ Cannabis ☐ Nicotine
☐	☐	Do you use any edible cannabis or CBD products?
☐	☐	Pregnant or nursing?
☐	☐	Have you ever taken an antibiotic prior to dental treatment?
☐	☐	Are you satisfied with your teeth's appearance?

PATIENT MEDICAL & DENTAL HISTORY

☐ ☐ Would you like to keep your teeth all your life?

Patient / Guardian Name: _____

Patient / Guardian Signature: _____ **Date:** _____