Medical History Update

Date ________________________

Patient Name: ____ **Patient Birthday:** ____________________

Are you under the care of a physician? ☐ Yes ☐ No Explain: ____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No Explain: ____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No Explain: ____

Are you taking any medications, pills, Or drugs? ☐ Yes ☐ No **List ALL Meds:** ____
____
____
(Bring with you OR attach a separate list if needed)

Do you take, or have you taken, Phen-fen or Redux? ☐ Yes ☐ No Explain: ____

Do you or have you ever taken Fosamax, Boniva, Actonel, or any other Bisphosphonate medication? ☐ Yes ☐ No Explain: ____

Are you on a special diet? ☐ Yes ☐ No Explain: ____

Do you use tobacco? ☐ Yes ☐ No Explain: ____

Do you use controlled substances? ☐ Yes ☐ No Explain: ____

Has a physician or previous dentist recommended you take antibiotic pre-medication prior to dental appointments? ☐ Yes ☐ No Explain: ____

WOMEN, are you? ☐ Pregnant/Trying to get Pregnant ☐ Nursing ☐ Taking ORAL contraceptives

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Are you ALLERGIC to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetic

Do you have any other known allergies? ☐ Yes ☐ No If yes, please list: ________________________________
____

Continue to Page 2 of Medical History... **Dr. Initials** ☐

Medical History, page 2 **Do you, or have you ever, had any of the below diseases or medical conditions? If NO to ALL, check here:** ☐

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medication ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatment ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis / Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells / Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack / Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers (stomach) ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble / Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Yellow Jaundice ☐ Yes ☐ No	**Anything else not listed above, explain:**		

I certify that I have read and understand the questions asked. I certify that I have answered the questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing the forms. I consent to the diagnostic procedures, including radiographs, and treatment by the dentist(s) of this office necessary for proper dental care.

Signature of Patient or Guardian: ________________________ **Date:** ____________ **Dr. Initials** ☐

Supplemental Questions

Name ________________________

Has there been any change to your health over the last year? ☐ **Y** ☐ **N** **If yes, explain:** ____

Date of last general medical exam? _______________, **Doctor's Name:** ____________________________, **Phone** _________________________

Medical Alerts

Previous Infective Endocarditis?	☐ Yes	☐ No	Prescription Blood Thinner (NOT just aspirin)	☐ Yes	☐ No
Damaged heart valves in a transplanted heart?	☐ Yes	☐ No	Blood Clot History?	☐ Yes	☐ No
Unrepaired cyanotic congenital heart disease?	☐ Yes	☐ No	TIA History?	☐ Yes	☐ No
Repaired (completely) CHD within the last 6-months?	☐ Yes	☐ No	Immunocompromised?	☐ Yes	☐ No
Repaired CHD with residual defects?	☐ Yes	☐ No	Total Joint Replacement(s)?	☐ Yes	☐ No

Appointment Considerations

I want Nitrous Oxide (Laughing Gas):	☐ Always	☐ Never	☐ Unsure	☐ Sometimes depending on the procedure	
Severe Dental Anxiety?	☐ Yes ☐ No		Mental Handicap?	☐ Yes	☐ No
Generalized Anxiety?	☐ Yes ☐ No		ADD/ADHA?	☐ Yes	☐ No
No Epinephrine due to medical reasons?	☐ Yes ☐ No		Hearing Aids / Problems?	☐ Yes	☐ No
Difficulty getting numb for treatment?	☐ Yes ☐ No	☐ DK	Parkinson's?	☐ Yes	☐ No
Anesthetic wears off quickly?	☐ Yes ☐ No	☐ DK	Dry Mouth Problems?	☐ Yes	☐ No
Physical Handicap?	☐ Yes ☐ No		Jaw/TMJ Surgery History?	☐ Yes	☐ No

Sleep

Sleep Apnea Diagnosis by MD?	☐ Yes	☐ No	CPAP for Sleep?	☐ Yes	☐ No	Acid Reflux?	☐ Yes	☐ No
Snoring (NOT diagnosed as apnea?	☐ Yes	☐ No	Oral Appliance for Sleep?	☐ Yes	☐ No			

Dental Specific Allergies

Fluoride	☐ Yes	☐ No	Acetaminophen	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No	☐ **No Dental Allergies**		

Dental Care History

Previous Dentist Name/Contact Info..................			**Fluoride Use**		
			Is your home water fluoridated?	☐ Y	☐ N
Reason for changing dentists, if applicable.........			Do you use toothpaste with fluoride?	☐ Y	☐ N
			Do you purposely avoid fluoride?	☐ Y	☐ N
Date of Last Dental Cleaning...............................					
			History Of:		
Your Frequency of Dental Cleanings, in months.	☐ 3 ☐ 4 ☐ 6 ☐ Other		Orthodontics/Braces?	☐ Y	☐ N
How often do you brush your teeth?			Currently wear Retainers?	☐ Y	☐ N
Manual or Electric Brush?	☐ M ☐ E ☐ Both		Oral Surgery?	☐ Y	☐ N
How often do you floss?			Dental Implants?	☐ Y	☐ N
Type of floss (string, handle, pik, waterpik, etc).			TMJ Therapy?	☐ Y	☐ N
Does food or floss catch between your teeth?	☐ Y ☐ N		Periodontal Cleanings?	☐ Y	☐ N
Cosmetics			Unfavorable past dental experience?	☐ Y	☐ N
Are you happy with your smile?	☐ Y ☐ N		If yes, explain:		
Do you want to whiten your teeth?	☐ Y ☐ N				

Dentures/Partials: Do you have a denture, complete or partial (NOT a bridge cemented over permanent teeth/roots)? ☐ **Y** ☐ **N**

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What date did you receive your FIRST denture?		Has your present denture ever been relined?	☐ Y	☐ N
How old is the CURRENT denture you have?		Is there a problem with your current denture?	☐ Y	☐ N

Signature of Patient or Guardian: _________________________**Date:** ____________ **Dr. Initials** [ ]