Name: _____

Medical History:

Physician/MD Name _____ Phone _____ Date of Last Visit _____

Are you currently being treated by a physician/M.D ☐Yes ☐No - Describe _____

Any serious illnesses/surgeries, or changes to health in last year? ☐Yes ☐No Describe_____

Are you pregnant? ☐Yes ☐No

Height _____ Are you nursing? ☐Yes ☐No

Weight _____ Taking Birth Control? ☐Yes ☐No

Have you used or are currently using recreational/street drugs? ☐Yes ☐No – What? _____ When _____
(Many of the drugs we use can have an adverse reaction with recreational drugs)

Have you ever taken a bisphosphonate drug such as Boniva, Fosamax, or other bone-sparing drug? ☐ Yes ☐ No

Do you use tobacco? Yes / No What type? _____ How Long & How Much? _____

Have you ever quit & when/how long_____ Are you interested in stopping? Very / Somewhat / Not

Do you drink alcohol? Yes / No If yes, how many drinks per day/week?_____

Check all that apply

- ○ AIDS/HIV Positive
- ○ Acid Reflux
- ○ Allergies to Anesthetic
- ○ Anaphylaxis
- ○ Anemia
- ○ Arthritis, Rheumatism
- ○ Artificial Heart Valves
- ○ Artificial Joint/Implant/ Prosthesis
- ○ Asthma
- ○ Blood Disease
- ○ Cancer
- ○ Chemical Disease
- ○ Chemotherapy
- ○ Circulatory Problems
- ○ Cortisone Treatments
- ○ Diabetes TYPE _____
- ○ Epilepsy
- ○ Fainting
- ○ Food Allergies
- ○ Glaucoma
- ○ Headaches
- ○ Hearing (Cochlear Implant)
- ○ Heart Murmur
- ○ Heart Problems
- ○ Describe:_____ _____ _____
- ○ Hemophilia/Abnormal Bleeding
- ○ Herpes
- ○ Hepatitis
- ○ High/ Low Blood Pressure
- ○ Jaundice
- ○ Jaw Pain
- ○ Kidney Disease/Malfunction
- ○ Liver Disease
- ○ Material Allergies (latex, wool, metal, chemicals)
- ○ Nervous Problems
- ○ Osteoporosis
- ○ Pacemaker
- ○ Psychiatric Care
- ○ Rapid weight gain/loss
- ○ Radiation Treatment
- ○ Respiratory Disease
- ○ Rheumatic/Scarlet Fever
- ○ Sinus Problems
- ○ Shingles
- ○ Shortness of Breath
- ○ Stroke
- ○ Surgical Implant
- ○ Thyroid Disease/Malfunction
- ○ TMJ
- ○ Tonsillitis
- ○ Ulcer/Colitis
- ○ Venereal Disease

List all medications you are currently taking, if any: _____

_____

List all allergies to drugs/medications, if any: _____

_____

(Fill Out Reverse Side)

Dental Health History

Approximately when was your last dental visit? _____

Do you have any specific dental concerns today? _____

Do you have dental pain currently? Yes / No Please rate on a scale of 1 – 10: _____

Do your gums bleed when you brush/floss? Yes / No

Are your teeth sensitive to: **Cold?** Yes / No **Hot?** Yes / No **Sweets?** Yes / No **Pressure?** Yes / No

Is your mouth dry frequently? Yes / No

Have you ever had periodontal (gum) treatments? Yes / No

Have you ever had orthodontic (braces) treatment? Yes / No

Do you have clicking, popping or discomfort in your jaw? Yes / No

Do you brux or grind your teeth? Yes / No

Do you wear Dentures or Partials? Yes / No If so what? _____

Do you have any history of facial trauma? Yes / No Explain: _____

Do you have fear of the dentist? Yes / No If so please rate on a scale of 1 – 10 : _____

What are you most concerned about when you have fear of dental visit? _____

Have you ever had problems with prior dental treatment? Explain:

_____

_____

Is there anything we can do to help improve your dental visit? _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the Dentist to help determine appropriate and healthful dental treatment. If there is any changes in my medical status, I will inform the Dentist.

Signature _____ Date _____