

## Patient Medical and Dental History

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last First MI

Patient Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Emergency Contact & Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_ Occupation \_\_\_\_\_

Physician Name \_\_\_\_\_ Physician Number \_\_\_\_\_

Do you have (new) insurance? \_\_\_\_\_ If yes, please present your insurance card so we may make a copy.

Who may we thank for referring you to our office? \_\_\_\_\_

**Allergies to:**

Latex: Yes No

Medications \_\_\_\_\_

Other \_\_\_\_\_

**PreMed required?**

(have you ever been told by a physician to take antibiotics for dental appointments?) Yes No

Reason: \_\_\_\_\_

Type: \_\_\_\_\_

Dosage: \_\_\_\_\_

**Current Medications** (Prescription, Over the counter and Herbal):

\_\_\_\_\_  
 \_\_\_\_\_

**PAST AND CURRENT MEDICAL CONDITIONS** (check all that apply)

	Y	N		Y	N
Under physician's care?			Asthma?		
Details:			Sleep Apnea?		
Hospitalization/surgery(s) in last 5 years?			Tuberculosis?		
Details:			Sinus trouble?		
Head/neck/mouth injuries?			Cancer?		
Women: pregnant?			Radiation Treatment to Head/Neck?		
Women: nursing?			Chemotherapy?		
Women: oral contraceptives?			Kidney Disease?		
Heart trouble/disease?			Dialysis?		
Rheumatic fever?			Eating Disorder?		
Are you taking or have you taken medications, alendronate (Fosamax) or risedronate (actonel) for osteoporosis or Page's disease?			Stomach: reflux? ulcer?		
Heart murmur?			Autoimmune disease?		
Mitral valve prolapse?			Sjogrens Disease?		
Heart surgery?			Fibromylagia?		
Artificial heart valves?			Other autoimmune disease (lupus, pemphilus)?		
Pacemaker?			Arthritis or other joint disorders?		
Indwelling defibrillator?			Diabetes? Type: _____ Controlled? Y N		
Artificial joints?			Headaches?		
History of Organ Transplant?			Depression: Diagnosed?		
High blood pressure? BP: /			Other Psychiatric Disorders?		
Stroke?			Neurologic Disease?		
Bleeding problem?			Convulsions?		
Hemophilia?			Epilepsy/seizures?		
Anemia?			Cerebral Palsy?		

	Y	N		Y	N
Leukemia?			Fainting/dizziness?		
Lung disease?			Alcohol or chemical dependency? Daily/ Weekly Qty		
Emphysema?			AIDS/HIV positive?		
Shortness of Breath?			Tobacco user? Type:		
Hepatitis?			Amount:		
Thyroid disease?			# of years:		
Glaucoma?			Are you interested in quitting tobacco?		

**DO YOU HAVE CONSISTENT PROBLEMS WITH:**

	Y	N
Dry mouth/excessive thirst?		
Sensitive teeth? Hot Cold Pressure Sweets		
Mouth odors/bad taste?		
Cold sores/blisters/oral lesions?		
Are you aware of any swelling or lumps?		
Sore, bleeding gums?		
Loose teeth?		
Difficulty chewing?		
Food catches between teeth? If yes, where?		
Teeth/fillings break frequently?		
Clenching or grinding habits?		
Do you hear popping, clicking or snapping?		
Do you have jaw pain?		
Are you nervous about dental work?		

**DENTAL INFORMATION:**

Previous dentist:
Last dental visit:
Last dental cleaning:
Frequency of brushing:
Frequency of flossing:
Family history of extensive decay?
Treatment for periodontal (gum) disease?
Family history of periodontal disease?
Have you had orthodontics (braces)?
Have you had oral surgery?
Have you had any dental implants placed?
Treatment for TMJ disorders?
Do you wear a denture(s) or partial denture(s)?
Any other concerns?
Chief dental complaint:

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Dentist

**Medical History Update**

Date	Comments	Signature	Date	Comments	Signature
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____