MEDICAL-DENTAL HISTORY

Name (Dr., Mr., Ms., Mrs.): ______________________________

What should we call you? ______________________________

Address: ______________________________

Date of birth: ______________________________

City: ______________________________ Zip Code: __________

Age: ______________________________

Home Phone: ______________________________

Occupation: ______________________________

Cell Phone: ______________________________

Employer: ______________________________

Work Phone: ______________________________

E-Mail: ______________________________

Referred by: ______________________________

Social Security Number: ______________________________

Name of Previous Dentist: ______________________________

Hobbies: ______________________________

Name of Family Physician: ______________________________

Dental Insurance: ☐ Yes ☐ No

Name of Cardiologist: ______________________________

Emergency Contact: ______________________________

Name of Other Medical Specialist(s): ______________________________

Office staff only

Blood pressure______________________ Pulse________________

Maximum opening___________ Mallampati Score _____________

Height____________________ Weight ____________________

---

1. Are you currently under the care of a physician? ☐ Yes ☐ No
2. Please list dates and reasons for hospitalizations and/or surgeries______________________________

____

3. Please list current medications you are taking______________________________-_____

____

4. Please list allergies to any drugs or medications______________________________

____

Have you ever been treated for the following conditions:

5. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? If yes, please specify ______________________________
6. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? If yes, please specify. ______________________________

____

Have you ever or are you currently been treated for the following conditions:

7. Excessive bleeding: ☐ Yes ☐ No List medications and dosage: ______________________________
8. Breathing problems, asthma, tuberculosis, hay fever: ☐ Yes ☐ No List medications and dosage: ______________________________
9. Cancer, x-ray treatment, or chemotherapy: ☐ Yes ☐ No List medications and dosage: ______________________________
10. Hepatitis, jaundice, or liver disease: ☐ Yes ☐ No List medications and dosage: ______________________________ _
11. Kidney problems or renal dialysis: ☐ Yes ☐ No List medications and dosage: ______________________________
12. Venereal disease or AIDS: ☐ Yes ☐ No List medications and dosage: ______________________________
13. A stroke, convulsions, or fainting spells: ☐ Yes ☐ No List medications and dosage: ______________________________
14. Tumors or growths: ☐ Yes ☐ No List medications and dosage: ______________________________
15. Arthritis or rheumatism: ☐ Yes ☐ No List medications and dosage: ______________________________
16. High cholesterol: ☐ Yes ☐ No List medications and dosage: ______________________________
17. High blood pressure: ☐ Yes ☐ No List medications and dosage: ______________________________
18. Diabetes: ☐ Yes ☐ No List medications and dosage: ______________________________

If yes: ☐Type 1 ☐ Type 2 When was your last AIC test result:_____________ How often are you tested: _______________

Do you take any of the following:

19. Pain medications: ☐ Yes ☐ No List medications and dosage: ______________________________

20. Anxiety or mind altering medications: ☐ Yes ☐ No List medications and dosage: ______________________________

21. Sleep medications: ☐ Yes ☐ No List medications and dosage: ______________________________

22. Osteoporosis medications: ☐ Yes ☐ No List medications and dosage: ______________________________

23. Aspirin: ☐ Yes ☐ No If yes, what dosage: ______________________________

24. Vitamin or herbal supplements: ☐ Yes ☐ No List medications and dosage: ______________________________

25. Please list any other medications you are taking and for what reason: ______________________________

____

26. Have you ever had a serious injury to your head or neck? If yes, describe. ______________________________

____

27. Do you smoke? ☐ Yes ☐ No If yes, describe type and frequency: ______________________________

28. For women: Are you pregnant or breastfeeding? ______________________________

DENTAL HISTORY

29. What would you like done for your mouth? ______________________________

30. Are you satisfied with the appearance of your teeth? ______________________________

31. Are you satisfied with your ability to chew? ______________________________

32. Are any of your teeth sensitive to heat, cold, or pressure: ☐ Yes ☐ No

33. Do you snore: ☐ Yes ☐ No

34. Have you been diagnosed with sleep apnea: ☐ Yes ☐ No If yes, do you use a breathing device: ______________________________

35. Do you get headaches or migraines: ☐ Yes ☐ No

37. Do you grind your teeth or clench your jaws: ☐ Yes ☐ No

38. Are there any sores or growths in your mouth: ☐ Yes ☐ No

39. Do any of your teeth ache: ☐ Yes ☐ No

In respect to previous dental treatment have you:

40. Ever fainted: ☐ Yes ☐ No

41. Had an allergic reaction: ☐ Yes ☐ No If yes, please describe: ______________________________

42. Had abnormal bleeding: ☐ Yes ☐ No

43. Other complications during or following dental treatment: ☐ Yes ☐ No If yes, please describe: ______________________________

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the above questions have been accurately answered.

Permission to release health information: *I grant the right to the dentist to release health information obtained from me, and information of dental treatment, to third party payors and/or health care practitioners.*

Person completing this form:

______________________________ ______________________________ ______________________________

Signature Printed Name Date

If other than patient, indicate relationship: ______________________________