Medical/Dental History

Name_____ Phone Number_____
(Last) (First) (Middle) (best # to contact)

Address_____

Date of Birth_____ M / F

Emergency Contact: Name_____ Phone Number_____

Patient (Guardian) Signature_____

Question	YES	NO	IF yes, comment
Are you under a physician's care?			
Have you ever been hospitalized, had a major operation, or serious head/neck injury?			
Are you taking any prescription medications, OTC medications, or supplements? If so, please list.			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Do you use or have you used tobacco products? If so, how much, how often?			
Do you drink alcohol currently or in the past? If so, how much?			
Do you or have you used illegal drugs?			

Women: Are you…

☐ Pregnant/Trying to get pregnant ☐ Nursing? ☐ Taking contraceptives?

Are you allergic to or reacted adversely to any of the following? Yes (check all that apply) No

☐ Latex ☐ Aspirin ☐ Codeine ☐ Penicillin
☐ Metal ☐ Acrylic ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Iodine ☐ Foods ☐ Other Drugs ☐ Other

Please explain symptoms from indications above.

Do you have, or have you had, any of the following?

AIDS/HIV positive	☐Yes ☐No	Excessive Thirst	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Diabetes	☐Yes ☐No	Sinus Trouble/Hay Fever	☐Yes ☐No	Cold Sores/ Fever Blisters	☐Yes ☐No
Renal Dialysis	☐Yes ☐No	Blood Transfusion	☐Yes ☐No	Heart Pacemaker	☐Yes ☐No
Emphysema	☐Yes ☐No	Liver Disease	☐Yes ☐No	Congestive Heart Failure	☐Yes ☐No
High Cholesterol	☐Yes ☐No	Cancer	☐Yes ☐No	Dementia/Alzheimer's	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Hepatitis A or B or C	☐Yes ☐No
Irregular Heartbeat	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Angina/Chest Pain	☐Yes ☐No
Kidney Problems	☐Yes ☐No	Congenital Heart Disorder	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No
Frequent Headaches	☐Yes ☐No	Venereal Disease	☐Yes ☐No	Hives or Rash	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Radiation Treatments	☐Yes ☐No	Fainting spells/Dizziness	☐Yes ☐No
Thyroid Disease	☐Yes ☐No	Drug Addiction	☐Yes ☐No	Frequent Cough	☐Yes ☐No
Osteoporosis	☐Yes ☐No	Herpes	☐Yes ☐No	COPD	☐Yes ☐No
Tumors or Growths	☐Yes ☐No	Arthritis/Gout	☐Yes ☐No	Bruise Easily	☐Yes ☐No
Psychiatric Care	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Lung Disease	☐Yes ☐No
Hemophilia	☐Yes ☐No	Asthma	☐Yes ☐No	Heart Attack/Failure	☐Yes ☐No
Recent Weight Loss	☐Yes ☐No	Blood Disease	☐Yes ☐No	Heart Murmur	☐Yes ☐No
Anemia	☐Yes ☐No	Stomach/Intestinal Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Stroke	☐Yes ☐No	Use of steroid medications	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Glaucoma	☐Yes ☐No		

Have you had or do you have any illness not listed? If yes, _____

Comments:

Dental History

What are your oral health needs at this time?_____

When was your last cleaning?_____ Last x-rays?_____

How often do you brush your teeth?_____Floss your teeth?_____

Do you have or have you had (concerning dental treatment)

☐ Gum disease	☐Periodontal surgery	☐ Implant	☐Braces
☐ Root canal	☐Abscessed tooth	☐Pain in Jaw/Surgery	☐Extractions
☐ Sensitivity to cold	☐Sensitivity to sweets	☐Sensitivity to hot	☐ Mouth Sores

Comments:

Do you ever (choose all that apply)

☐ Clench	☐Grind	☐ Chew on one side	☐Difficult swallowing
☐ Mouth Breathe	☐Chew on foreign objects/fingernails		