

MEDICAL-DENTAL HISTORY

Name (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 Dentist: _____

Hobbies: _____

Name of Family Physician: _____

Dental Insurance: Yes No

Name of Cardiologist: _____

Emergency Contact: _____

Name of Pain Management Physician: _____

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 _____

3. Please list medications _____

4. Please list allergies to 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 A1C 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 about 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: _____

I grant permission for x-rays, photos, and any materials associated with my case to be used for teaching purposes to teach other dentists and dental staff.

Signature