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: _____

Where have you heard about us? Please check all that apply:

☐ Television ☐ Friend ☐ Internet ☐ Sign ☐ Radio ☐ Newspaper

☐ Other: _____

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1. Are you currently under the care of a physician? ☐ Yes ☐ No

2. Please list dates and reasons for hospitalizations _____

_____

3. Please list allergies to drugs or medications _____

_____

Have you ever been treated for the following conditions:

4. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? If yes, please specify. _____

_____

5. 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:

6. Excessive bleeding: ☐ Yes ☐ No List medications and dosage: _____

7. Breathing problems, asthma, tuberculosis, hay fever: ☐ Yes ☐ No List medicationsand dosage: _____

8. Cancer, x-ray treatment, or chemotherapy: ☐ Yes ☐ No List medicationsand dosage: _____

9. Hepatitis, jaundice, or liver disease: ☐ Yes ☐ No List medicationsand dosage: _____

10. Kidney problems or renal dialysis: ☐ Yes ☐ No List medicationsand dosage: _____

11. Venereal disease or AIDS: ☐ Yes ☐ No List medicationsand dosage: _____

12. A stroke, convulsions, or fainting spells: ☐ Yes ☐ No List medicationsand dosage: _____

13. Tumors or growths: ☐ Yes ☐ No List medicationsand dosage: _____

14. Arthritis or rheumatism: ☐ Yes ☐ No List medicationsand dosage: _____

15. High cholesterol: ☐ Yes ☐ No List medicationsand dosage: _____

16. High blood pressure: ☐ Yes ☐ No List medicationsand dosage: _____

17. Diabetes: ☐ Yes ☐ No List medicationsand 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:

18. Pain medications: ☐ Yes ☐ No List medicationsand dosage: _____

19. Anxiety or mind altering medications: ☐ Yes ☐ No List medicationsand dosage: _____

20. Sleep medications: ☐ Yes ☐ No List medicationsand dosage: _____

21. Osteoporosis medications: ☐ Yes ☐ No List medicationsand dosage: _____

22. Aspirin: ☐ Yes ☐ No If yes, what dosage: _____

23. Vitamin or herbal supplements: ☐ Yes ☐ No List medicationsand dosage: _____

24. Please list any other medications you are taking and for what reason: _____

_____

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

_____

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

27. For women: Are you pregnant or breastfeeding? _____

DENTAL HISTORY

28. What would you like done for your mouth? _____

29. Are you satisfied with the appearance of your teeth? _____

30. Are you satisfied with your ability to chew? _____

31. Does food catch between your teeth: ☐ Yes ☐ No

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

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

37. Do you have pain or clicking in the jaw joint around your ear: ☐ Yes ☐ No

38. Have your jaw muscles ever been sore: ☐ Yes ☐ No If yes, please describe_____

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

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

In respect to previous dental treatment have you:

41. Ever fainted: ☐ Yes ☐ No

42. Had an allergic reaction: ☐ Yes ☐ No If yes, please describe: _____

43. Had abnormal bleeding: ☐ Yes ☐ No

44. 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 my 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