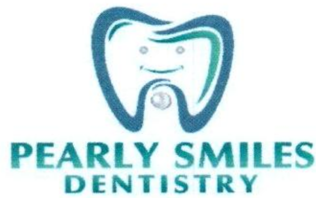

Medical History

Patients Name: ______________________________________

Date of Birth: ______________________

Do you have any allergies to

Y/N Aspirin
Y/N Codeine
Y/N Latex
Y/N Local Anesthetic
Y/N Penicillin
Y/N Sulfa
List any other allergies: ____

Conditions:

Y/N (High/Low) Blood Pressure
Y/N Anemia
Y/N Bleeding Problems
Y/N Diabetes
Y/N Artificial Heart Valves
Y/N Blood Disease
Y/N Congenital Heart Lesions
Y/N Heart Problems
Y/N Pacemaker
Y/N Arthritis
Y/N Rheumatism
Y/N Gout
Y/N Ulcer
Y/N Epilepsy
Y/N AIDS/HIV
Y/N Asthma
Y/N Cancer
Y/N Chemo/radiation Therapy
Y/N Emphysema
Y/N Glaucoma
Y/N Shortness of Breath/breathing problems
Y/N Sinus Trouble
Y/N Stroke
Y/N Thyroid Problems
Y/N Tuberculosis
Y/N Tumor/growth
Y/N Fainting/Dizziness
Y/N Headaches

Y/N Hepatitis (A,B or C)

Y/N Herpes

Y/N Kidney Disease

Y/N Liver Disease

Y/N Nervous Problems

Y/N Psychiatric Care

Y/N Pregnant

Y/N Nursing

List any other medical issues you have: ________________________________

____

List any serious Illnesses / surgeries: ________________________________

____

Has the patient ever been hospitalized? **Y/N**
-Please state the reason for hospitalization:

____

Do you require ANY antibiotics prior to dental treatment? **Y/N**
-If yes, for what: ________________________________

Are you taking any medications? **Y/N**
List all medications and dose you are taking **(REQUIRED)**

____

Are you currently or have you ever taken medication for Osteoporosis? **Y/N**

If yes, what medication are you taking or have taken in past and for how long?

____

Do you or have you previously Vaped, used Medical Marijuana, or Tobacco/Nicotine or Smoked? **Y/N**

If yes, how often/how long? ________________________________

Do you drink Alcohol? **Y/N**

High Sugar intake? **Y/N**

Are under the care of a physician? **Y/N**

Physician Name/phone number: ________________________________

Is the patient physically, mentally or emotionally impaired? **Y/N**

Dental History

When was your last dental visit?____________________ Last dental cleaning?__________________

How would you describe your dental health at present? **Good** **Fair** **Poor**

How often do you brush? ___________________________ Floss?______________________________

What are your present dental concerns, if any?

Bleeding Gums **Crooked teeth** **Cosmetic** **Loose teeth** **Bad breath**

Food trapping **Sensitive teeth** **Toothache** **Loose dentures** **Missing teeth**

Want whiter teeth **Other:**____

Are you happy with the appearance of your teeth? **Y/N**

Are you anxious during dental visits? **Y/N**

Have you ever had any complications following dental treatment? **Y/N**

If yes, please explain: ____

Are you wearing removable dental appliances? **Y/N**

Signature of Patient/Guardian:

____ Date:____________________

SIGNATURE OF TREATING DENTIST

____ Date: ____________________