Dental Medical History

Name: _________________________________________ Preferred Name: ______________________________ Pronouns: ____________

CHECK THE APPROPRIATE ANSWER

1. Purpose of visit: _____________________________________________________________
2. How long has it been since your last dental treatment: ____________________________
3. Are any of your teeth sensitive to: □ Hot □ Cold □ Sweets □ Pressure? If so, which teeth? □ YES □ NO
4. Are you experiencing any pain or discomfort at this time? □ YES □ NO
5. Have you ever had gum treatment or gum surgery? □ YES □ NO
6. Do your gums bleed or hurt? □ YES □ NO
7. Do you have any sores or lumps in or near your mouth? □ YES □ NO
8. Does your jaw pop or click? □ YES □ NO
9. Do you often have headaches, neck aches or shoulder aches? □ YES □ NO
   What time of day? □ Morning □ Night
10. Have you experienced pain or difficulty when chewing? □ YES □ NO
11. Have you experienced difficulty in opening and closing? □ YES □ NO
12. Do you clench or grind your teeth (while awake or asleep)? □ YES □ NO
13. Are you happy with the appearance of your teeth? □ YES □ NO
14. Have you ever had any problems or complications with previous dental treatment? □ YES □ NO
15. How often do you brush and floss your teeth? ___________________________________
16. Physician’s (or medical clinic’s) name? _________________________________________
17. When was your last physical exam? ____________________________________________
18. Are you under the care of a physician? □ YES □ NO
   Since when? _____________ Why? ____________________________________________
19. Has there been any change in your general health within the past year? □ YES □ NO
20. Have you ever had a serious illness or major surgery? □ YES □ NO
   If so, explain: ________________________________________________________________
21. Are you allergic or have sensitivities to any medications or substances? □ YES □ NO
   If so, explain: ________________________________________________________________
22. Do you have other allergies or sensitivities? □ YES □ NO
23. Have you ever had any problems with (or adverse reactions to) penicillin or other antibiotics, sulfa drugs, anesthetics, or other medications? □ YES □ NO
24. Are you sensitive to any metals, latex or other materials? □ YES □ NO
25. Are you taking medications? (Include antibiotics) □ YES □ NO
   Please list & Explain: _________________________________________________________
26. Are you taking any over the counter medications and/or supplements? □ YES □ NO
   Please list: __________________________________________________________________
27. Have you ever taken any prescription weight loss medications? □ YES □ NO
Dental Medical History (continued)

29. Are you taking any bisphosphonate medications (i.e. Fosamax, Boniva)? ............................................. □YES □NO
30. Are you being or have you been treated for chemical dependency? .......................................................... □YES □NO
31. Do you smoke, chew, use snuff or any other forms of tobacco? .............................................................. □YES □NO
32. Are you pregnant or do you suspect you may be? .................................................................................. □YES □NO
   How many weeks / due date: ________________________________________________________________
33. Have you had or do you test positive for hepatitis? .............................................................. □YES □NO
34. Have you tested HIV positive? ................................................................................ □YES □NO
35. Have you ever been treated or been told that you might have a heart condition, heart disease or a heart murmur? □YES □NO
36. Do you have a pacemaker, artificial heart valve implant, artificial joints, implants, or prosthesis? ........ □YES □NO
37. Do you have or have you ever had any of the following diseases, or conditions? If you answer yes, please indicate when.
   a. Prolapsed mitral valve? .................................................................................................................. □YES □NO
   b. High or low blood pressure? ........................................................................................................ □YES □NO
   c. Stroke? ........................................................................................................................................... □YES □NO
   d. Asthma or sinus trouble? ............................................................................................................... □YES □NO
   e. Tuberculosis (T.B.)? ..................................................................................................................... □YES □NO
   f. Epilepsy or seizure disorder? ........................................................................................................ □YES □NO
   g. Diabetes? ....................................................................................................................................... □YES □NO
   h. Thyroid problems? ........................................................................................................................ □YES □NO
   i. Stomach ulcers? ............................................................................................................................ □YES □NO
   j. Eating disorders? .......................................................................................................................... □YES □NO
   k. Kidney trouble, transplant or dialysis? .......................................................................................... □YES □NO
   l. Liver disease or jaundice................................................................................................................ □YES □NO
   m. Rheumatic fever, scarlet fever, or rheumatic heart disease? ....................................................... □YES □NO
   n. Inflammatory diseases (arthritis, rheumatism)? ........................................................................... □YES □NO
   o. Any sexually transmitted disease? .............................................................................................. □YES □NO
   p. If you are 26 years old or younger have you completed the HPV series? .............................. □YES □NO
   q. Bled excessively after being cut or injured? ............................................................................... □YES □NO
   r. Any blood disorders (anemia, leukemia, etc.)? .......................................................................... □YES □NO
38. Is there anything else we should know about your health that we have not covered in this form? .......... □YES □NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient’s signature: ___________________________________________ Date: ______________________

Provider’s signature: _________________________________________ Date: ______________________