Patient Name: _____

MEDICATIONS

During the past year have you taken any of the following?

☐Antibiotics ☐Insulin

☐Blood Thinners ☐Heart Drugs

☐Antidepressants ☐Antianxiety med

☐Blood Pressure Meds ☐Birth Control

☐Cholesterol Meds ☐Dilantin

☐Bisphosphonates (Fosamax) ☐Cancer Meds

Other Medications Please List:_____

_____

_____

ALLERGIES

Are you allergic to or have you had a reaction to any of the following (please circle):

Latex Anesthetic Aspirin

Codeine Penicillin Metals

Sulfa Drugs Animals Food

Reaction:_____

Other Allergies:_____

MEDICAL HISTORY

Are you under the care of a physician? ☐ YES ☐NO

Have you ever been hospitalized? ☐YES ☐NO
Reason?_____

Are you pregnant/nursing? ☐YES ☐NO

Have you ever, or do you now use controlled substances? ☐YES ☐NO

Do you use tobacco products? ☐YES ☐NO

Please check if you have, or have had any of the following medical conditions:

☐Congenital Heart Disease ☐Heart Attack

☐Mitral Valve Prolapse ☐Pacemaker

☐Artificial Heart Valve ☐Stents

☐High Blood Pressure ☐Chest Pain

☐Low Blood Pressure ☐Cancer

☐Heart Transplant ☐Diabetes

☐Artificial Joints ☐Asthma

☐Chemo/Radiation ☐Blood Disease

☐Shortness of Breath ☐Emphysema

☐Epilepsy/Seizures ☐Osteoporosis

☐Abnormal Bleeding ☐Dry Mouth

☐Fainting/Dizziness ☐Hemophilia

☐Hepatitis A, B, or C ☐HIV/AIDS

☐Hypoglycemia ☐Leukemia

☐Kidney Problems ☐Shingles

☐Rheumatic Fever ☐Rheumatism

☐Scarlet Fever ☐Sinus Trouble

☐Multiple Sclerosis ☐Tuberculosis

☐Thyroid Disease ☐Ulcers

☐Venereal Disease ☐Glaucoma

☐Frequent Cough ☐Anemia

☐Mental Health Disorder ☐Stroke

☐High Stress Level ☐COPD

Other Medical Conditions Not Listed: _____

_____

_____

_____

DENTAL HISTORY

What is the reason for your dental visit today?

_____

_____

Are you apprehensive about dental treatment?

☐YES ☐NO

Are you experiencing dental pain now?

☐YES ☐NO

If so, where?

_____

Is the pain associated with (please circle)…….

Cold Hot Sweets Pressure

Do you have difficulty chewing your food?

☐YES ☐NO

Does your breath concern you?

☐YES ☐NO

Do your gums bleed when your brush or floss?

☐YES ☐NO

Have you ever been diagnosed with periodontal (gum) disease?

☐YES ☐NO

Do you have a family history of gum disease?

☐YES ☐NO

Is your home water supply fluoridated?

☐YES ☐NO

Do you drink tap water or bottled/filtered water? How often?

_____

Have you ever had orthodontic (braces) treatment?

☐YES ☐NO

Do you have sores or ulcers in your mouth?

☐YES ☐NO

If you use tobacco products, what type do you use and how often?

_____

Do you experience dry mouth?

☐YES ☐NO

How many times a day do you brush your teeth? _____

How often are you flossing? _____

Do you clench or grind your teeth?

☐YES ☐NO

Does your jaw hurt when you chew or open it wide to take a bite?

☐YES ☐NO

Has any medical doctor advised you take a pre-medication prior to dental care?

☐YES ☐NO

Do you wear any type of retainer, night-guard or removable oral appliance (partial/denture)?

☐YES ☐NO

If yes, please describe: _____

Date of last dental exam: _____

What was done at that time? _____

_____

Date of last dental x-rays: _____

How do you feel about your smile? _____

_____

_____