Medical History Form3/21/2019

Patient Name: Birth Date: Date Created:

Please complete the following medical history form honestly. Our office adheres to written policy and procedures to protect the privacy of information we receive.

Health conditions you may have or medications you may be taking, could have a direct relationship on the dental care you will receive. Thank you!

General Health Questions:

Are you currently under a physician's care?	○ Yes ○ No	If yes
Have you been hospitalized in the last year?	○ Yes ○ No	If yes
Have you ever had a major operation?	○ Yes ○ No	If yes
Have you ever taken medications for osteoporosis?	○ Yes ○ No	If yes
Have you ever been told you need an antibiotic BEFORE dental treatment?	○ Yes ○ No	If yes

Medications

Are you currently taking any medications or pills ? ○ Yes ○ No

If YES plase list name, dose and what time of day you take the medication:

Allergies:

Do you have seasonal or environmental allergies? ○ Yes ○ No

Have you or anyone in your family, ever had an adverse reaction to local or general anesthesia? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin	☐ Ibuprofen	☐ Latex	☐ Codeine
☐ Antibiotics	☐ Local Anesthetics	☐ Opioids	☐ Food (gluten, shellfish, ect)

Are you allergic or sensitive to any other substances? Please List:

Current Health:

Do you have, or have you had, any of the following?

1. Cardiac/Organ Transplant ○ Yes ○ No	8. Joint Replacement ○ Yes ○ No	15. Cancer ○ Yes ○ No	22. Tuberculosis ○ Yes ○ No
2. Heart Surgery ○ Yes ○ No	9. High Cholesterol ○ Yes ○ No	16. Chemotherapy ○ Yes ○ No	23. Asthma ○ Yes ○ No
3. History of Endocarditis ○ Yes ○ No	10. High blood pressure ○ Yes ○ No	17. Radiation Therapy ○ Yes ○ No	24. Hepatitis A, B or C ○ Yes ○ No
4. Cardiac Pacemaker ○ Yes ○ No	11. Stroke ○ Yes ○ No	18. Diabetes ○ Yes ○ No	25. Immune Supression, HIV or AIDS ○ Yes ○ No
5. Congenital Heart Condition ○ Yes ○ No	12. Bleeding Disorders ○ Yes ○ No	19. Kidney/Renal Disease ○ Yes ○ No	26. Epilepsy/Seizures ○ Yes ○ No
6. Heart Attack ○ Yes ○ No	13. Mental Health Disorder ○ Yes ○ No	20. Thyriod Disorder ○ Yes ○ No	27. Glaucoma ○ Yes ○ No
7. Artificial/Damaged Heart Valve ○ Yes ○ No	14. Liver Disease ○ Yes ○ No	21. Bisphosphonate Th ○ Yes ○ No	

Please explain any YES answers: (Include question #)

Please list any conditions or serious illness not listed above:
Please list INR, HbA1C if known:

For Women, Are you:

Pregnant/Trying to get pregnant ○ Yes ○ No	Nursing? ○ Yes ○ No	Taking Oral Contraceptives? ○ Yes ○ No

Dental History:

Have you had dental x-rays within the past year? ◯ Yes ◯ No

When was your last dental visit?

What was completed at that visit?

☐ Cleaning ☐ Fillings ☐ Extractions

Answer the following questions:

Have you ever had braces? ◯ Yes ◯ No

Have you ever had jaw surgery? ◯ Yes ◯ No

Have you been vaccinated for HPV? (Human Papillomavirus) ◯ Yes ◯ No

Have you ever had gum treatment? ◯ Yes ◯ No

Have you had your wisdom teeth removed ? ◯ Yes ◯ No

Dental pain or concerns

Do you have any of the following?

Broken teeth? ◯ Yes ◯ No

Dental anxiety? ◯ Yes ◯ No

Tooth sensitivity to hot/cold? ◯ Yes ◯ No

Pain in jaw? ◯ Yes ◯ No

Tooth sensitivity to biting/chewing? ◯ Yes ◯ No

Dry Mouth? ◯ Yes ◯ No

Do you have any oral health concerns? If yes please breifly describe:

Tobacco use

Do you smoke or use tobacco products? ◯ Yes ◯ No

How long have you used tobacco?

How much do you use daily?

Indicate type of tobacco or product used:

☐ Cigarettes ☐ Chewing/Smokeless Tobacco ☐ Vapor/E-Cigarette ☐ Medical or Recreational Cannabis

Have you tried quitting before? ◯ Yes ◯ No

Are you interested in quitting? ◯ Yes ◯ No

Created 3/2019 by B Karkula LDH