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

- Have you been hospitalized in the last year?  
  - Yes  
  - No

- Have you ever had a major operation?  
  - Yes  
  - No

- Have you ever taken medications for osteoporosis?  
  - Yes  
  - No

- Have you ever been told you need an antibiotic before dental treatment?  
  - Yes  
  - No

**Medications**

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

If YES please 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
  - Opioids
  - Codeine
  - Food (gluten, shellfish, etc)

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

**Current Health:**

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

- Cardiac/Organ Transplant
- Heart Surgery
- History of Endocarditis
- Cardiac Pacemaker
- Congenital Heart Condition
- Heart Attack
- Artificial/Damaged Heart Valve
- Joint Replacement
- High Cholesterol
- High Blood Pressure
- Stroke
- Bleeding Disorders
- Mental Health Disorder
- Liver Disease
- Cancer
- Chemotherapy
- Radiation Therapy
- Diabetes
- Kidney/Renal Disease
- Thyroid Disorder
- Boshosphonate Therapy
- Tuberculosis
- Asthma
- Hepatitis A, B or C
- Immune Suppression, HIV or AIDS
- Epilepsy/Seizures
- Glaucoma

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 tooth?  
  - 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 briefly 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

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