## Medical History  Patient:_____

***1. Are you currently under the care of a medical doctor? Yes No***
***If yes, for what condition/s are you being treated?***

_____

***3. When was your last medical check-up?*** _____

***2. Do you have a family doctor? Name:*** _____
***Phone Number:*** _____

***4. Have you experienced excessive weight gain or loss recently? Yes No***

***5. Women: Are you currently pregnant or breast feeding? Yes No***

***6. Have you been hospitalized previously? Reason*** _____

_____

***7. Have you ever been diagnosed or treated for any of the following conditions?***

| | Yes | No |
|---|---|---|
| ***Heart problems*** | | |
| 1. Heart failure | ☐ | ☐ |
| 2. Heart disease | ☐ | ☐ |
| 3. Heart Murmur | ☐ | ☐ |
| 4. Angina Pectoralis or chest pain | ☐ | ☐ |
| 5. Heart attack | ☐ | ☐ |
| 6. High blood pressure | ☐ | ☐ |
| 7. Low blood pressure | ☐ | ☐ |
| 8. Rheumatic Fever | ☐ | ☐ |
| 9. Mitral valve prolapse | ☐ | ☐ |
| 10. Arrhythmia | ☐ | ☐ |
| 11. Stroke | ☐ | ☐ |
| 12. Congenital heart defect | ☐ | ☐ |
| ***Blood Disorders*** | | |
| 13. Hemophilia | ☐ | ☐ |
| 14. Anemia | ☐ | ☐ |
| 15. Leukemia | ☐ | ☐ |
| 16. Prolonged bleeding | ☐ | ☐ |
| ***Breathing and Lungs*** | | |
| 17. Hay fever | ☐ | ☐ |
| 18. Sinus problems | ☐ | ☐ |
| 19. Tuberculosis | ☐ | ☐ |
| 20. Asthma | ☐ | ☐ |
| 21. Chronic Obstructive Pulmonary Disease | ☐ | ☐ |
| 22. Emphysema | ☐ | ☐ |
| ***Digestive Problems*** | | |
| 23. Chrones disease | ☐ | ☐ |
| 24. Ulcerative colitis | ☐ | ☐ |
| 25. Celiac disease | ☐ | ☐ |
| 26. Kidney disease | ☐ | ☐ |
| 26. G.E.R.D. (Gastro-esophageal reflux disease) | ☐ | ☐ |
| 28. Liver disease | ☐ | ☐ |
| 29. Stomach or duodenal ulcers | ☐ | ☐ |
| ***Metabolic Disorders*** | | |
| 30. High Cholesterol | ☐ | ☐ |
| 31. Diabetes | ☐ | ☐ |
| 32. Hyperthyroidism | ☐ | ☐ |
| 33. Osteoporosis | ☐ | ☐ |
| 34. Hormone deficiency | ☐ | ☐ |
| 35. Addison's disease | ☐ | ☐ |
| 36. Cushing's disease | ☐ | ☐ |
| ***Viral ailments*** | | |
| 37. Hepatitis A B C ____ | ☐ | ☐ |
| 38. AIDS/HIV | ☐ | ☐ |
| 39. Cold sores | ☐ | ☐ |
| ***Other Conditions*** | | |
| 40. Epilepsy | ☐ | ☐ |
| 41. Malignant hyperthermia | ☐ | ☐ |
| 42. Arthritis | ☐ | ☐ |
| 43. Glaucoma | ☐ | ☐ |
| 44. Frequent headaches | ☐ | ☐ |
| 45. Fibromyalgia | ☐ | ☐ |
| 46. Bulimia/Anorexia | ☐ | ☐ |
| 47. Cancer | ☐ | ☐ |
| 48. Substance abuse | ☐ | ☐ |
| 49. Do you smoke | ☐ | ☐ |
| 50. Do you have a hearing impairment | ☐ | ☐ |
| 51. Psychiatric ailment | ☐ | ☐ |

***8. Have you ever experienced a reaction to, or are aware of an existing allergy to any of the following?***

| | Yes | No |
|---|---|---|
| a. Metals ( gold, silver, nickel ) _____ | ☐ | ☐ |
| b. Local anesthetics or general anesthetics _____ | ☐ | ☐ |
| c. Latex _____ | ☐ | ☐ |
| d. Aspirin, acetaminophen, ibuprophen _____ | ☐ | ☐ |
| e. Tetracycline _____ | ☐ | ☐ |
| f. Fluoride _____ | ☐ | ☐ |
| g. Penicillin _____ | ☐ | ☐ |
| h. Codeine _____ | ☐ | ☐ |
| i. Sulfa based medications _____ | ☐ | ☐ |
| j. Known allergy to other medications: (please list) | | |

_____

_____

***9. Are you currently taking any of the following medications?***

| | Yes | No |
|---|---|---|
| a. Bisphosphonates (Fosamax, Didrocal, Actonel, Aclasta or Fosavance) _____ | ☐ | ☐ |
| b. High blood pressure medication _____ | ☐ | ☐ |
| c. Antidepressant medications _____ | ☐ | ☐ |
| d. Steroid or corticosteroids( including prednisone ) _____ | ☐ | ☐ |
| e. Nitroglycerine _____ | ☐ | ☐ |
| f. Dilantin or anticonvusants _____ | ☐ | ☐ |
| g. Blood thinners (plavix, heparin, coumadin, warfarin) ____ | ☐ | ☐ |
| h. Birth control pill _____ | ☐ | ☐ |
| i. Insulin, metformin, tolbutamide _____ | ☐ | ☐ |
| j. tranquilizers _____ | ☐ | ☐ |
| k. Antibiotics _____ | ☐ | ☐ |
| i. Do you take other medications: ( please list below ) ____ | ☐ | ☐ |

_____

_____

***10. Have you or are you currently undergoing any of the following medical procedures?***

| | Yes | No |
|---|---|---|
| a. An artificial joint replacement _____ | ☐ | ☐ |
| b. An artificial heart valve placement _____ | ☐ | ☐ |
| c. An organ transplant _____ | ☐ | ☐ |
| d. Chemotherapy for cancer _____ | ☐ | ☐ |
| e. Radiation therapy for cancer _____ | ☐ | ☐ |
| f. Blood transfusion _____ | ☐ | ☐ |
| g. Dialysis _____ | ☐ | ☐ |
| h. Pacemaker or defibrillator _____ | ☐ | ☐ |
| i. Have you experienced complications due to treatment? _ | ☐ | ☐ |

***11. Have you or are you currently being treated for a mental illness?*** Yes No

*To the best of my knowledge, all of the information provided above is true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medications or medical status change, I will inform the dentist at my next dental visit.*

_____ _____ _____
*Date* *Patient, Parent or Legal Guardians Name* *Patient, Parent or Legal Guardians Signature*

_____ _____ _____
*Date* *Reviewed By* *Reviewers Signature/Witness*

| | | | |
|---|---|---|---|
| Name (Mr, Mrs, Ms) | Age | Sex | Date of Birth (DD/MM/YR) _____/_____/_____ |
| Address | Postal Code | | |
| Home Phone | Business Phone | | |
| Occupation | Place of Employment | | |
| Emergency Contact | Phone number | | |
| Physician | Physician Phone number | | |
| Primary Dental Insurance | Group/Policy# | ID# | |
| Secondary Dental Insurance | Group/Policy# | ID# | |
| Secondary policy holders name | | Date of Birth (DD/MM/YR) _____/_____/_____ | |
| How did you hear about our office? | | Referred by? | |
| Email address | (We hope to provide an email confirmation service in the future. This is optional) | | |

## *Dental History Questionnaire*

| | Yes | No |
|---|---|---|
| ***Personal Dental History*** | | |
| 1. Are you fearful of dental treatment? | ☐ | ☐ |
| *2. Have you had an unfavorable dental experience?* | ☐ | ☐ |
| *3. Have you ever had complications following dental treatment?* | ☐ | ☐ |
| *4. Do you have trouble getting numb or have had reactions to dental anesthetics?* | ☐ | ☐ |
| *5. Have you had teeth removed in the past?* | ☐ | ☐ |
| ***Smile characteristics*** | | |
| *6. Is their anything about the appearance of your teeth that you would like changed?* | ☐ | ☐ |
| *7. Have you ever bleached your teeth?* | ☐ | ☐ |
| *8. Are you self conscious about your teeth or smile?* | ☐ | ☐ |
| *9. Have you been disappointed with the appearance of past dental work?* | ☐ | ☐ |
| ***Bite and Jaw Joint*** | | |
| *10. Do you or would you have difficulty chewing gum?* | ☐ | ☐ |
| *11. Do you or would you experience difficulties chewing bagels or other hard foods?* | ☐ | ☐ |
| *12. Have your teeth become shorter, thinner or worn over the last 5 years?* | ☐ | ☐ |
| *13. Have your teeth become crowded or developed spaces between them in the last 5 years?* | ☐ | ☐ |
| *14. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?* | ☐ | ☐ |
| *15. Do you have troubles sleeping or wake up with an awareness of your teeth?* | ☐ | ☐ |
| *16. Do you or have you experienced problems with your jaw joint? (pain, clicking, popping, sounds)* | ☐ | ☐ |
| *17. Has your jaw ever locked open or shut?* | ☐ | ☐ |
| *18. Have you ever worn a bite appliance or night guard?* | ☐ | ☐ |
| *19. Do you experience frequent tension headaches or sore teeth?* | ☐ | ☐ |
| ***Tooth Structure*** | | |
| *20. Have you had a cavity within the last two years?* | ☐ | ☐ |
| *21. Do you experience a dry mouth?* | ☐ | ☐ |
| *22. Are your teeth sensitive to hot, cold or sweets?* | ☐ | ☐ |
| *23. Have you ever had a cracked tooth and or filling, toothache or broken tooth?* | ☐ | ☐ |
| *24. Do you avoid brushing or eating in any particular part of the mouth?* | ☐ | ☐ |
| ***Gum and Bone*** | | |
| *25. Have you ever been diagnosed with or treated for periodontal (gum) disease?* | ☐ | ☐ |
| *26. Have you experienced gum recession?* | ☐ | ☐ |
| *27. Do your gums bleed when you floss or brush?* | ☐ | ☐ |
| *28. Is their a history of anyone in your immediate family with early tooth loss or periodontal disease?* | ☐ | ☐ |
| *29. Are your teeth becoming loose?* | ☐ | ☐ |
| *30. Have you ever noticed or experienced an unpleasant odor or taste in your mouth?* | ☐ | ☐ |