Patient Medical History

Patient Name:	Preferred Name:
Reason for visit:	Date of last dental visit/x-rays:
Physician / Clinic :	Physician Phone # or Location:
Pharmacy:	Pharmacy Phone #:

How often do you brush? _____ How often do you floss?_____
Do you smoke or use smokeless tobacco products/e-cigarettes? _____ if so how much _____

Medications (please include supplements/ over-the-counter medications) *It is especially important to know if you are taking bone /osteoporosis medications (Boniva ,Fosamax, Prolia), blood thinners (aspirin), steroid medicines, nitroglycerin, arthritis, thyroid, tranquilizers, or Phenobarbital/ Dilantin.

_____

_____

Gender [ ]M [ ] F If Female, please answer the following:
Are you on birth control Y N Are you Pregnant (if so # of weeks) Y N _____ Are you nursing? Y N

Allergies: (circle any that apply) Aspirin Codeine Dental Anesthetics Erythromycin Latex Metals Penicillin Sulfa Tetracycline Other _____

Circle Yes or No

Y N Are you currently under a physician's care? (If so, for what?) _____
Y N Have you had any illness or surgery in the past year? (If so, what?)_____
Y N Are you having pain or discomfort now? (If so, where?)_____
Y N Do your gums bleed when you brush/floss? (If yes for how long?) _____
Y N Have you had periodontal or gum treatment? (If yes, when?)_____
Y N Have you had any undesirable treatment experience? (If so, what?) _____
Y N Do you have any sores or lumps in your mouth that don't heal? _____
Y N Are you unhappy with your smile?(If so, why?) _____
Y N Have you had braces/orthodontic treatment? (If yes when?) _____
Y N Are you changing dentists for any particular reason? (If so, why?)_____

Conditions: **Check all that apply** **List any not found below** _____

- ☐ Acid Reflux/ GERD
- ☐ ADD/ ADHD/or sensory disorder
- ☐ *Allergies (to what?)_____
- ☐ Anemia
- ☐ Angina Pectoris (chest pain)
- ☐ Arthritis
- ☐ *Artificial Joints(when?)_____
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Auto-Immune Disorder
- ☐ Blood Transfusion
- ☐ *Bone replacement/Osteoporosis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chemical Dependency
- ☐ Congenital Heart Defect
- ☐ Congestive Heart Failure
- ☐ Dental Implants
- ☐ Diabetes (if so Type I or II)_____
- ☐ Dry Mouth
- ☐ Eating Disorders
- ☐ Emphysema /COPD
- ☐ Fainting Spells
- ☐ Frequent Headaches /Migraines
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ *Heart Attack (when?)_____
- ☐ Heart Murmur
- ☐ Heart Surgery (when?)_____
- ☐ Hemophilia/ Clotting disorder
- ☐ Hepatitis A, B and/or C
- ☐ Herpes / Cold Sores
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV+ AIDS
- ☐ *Joint Replacement (when?) _____
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Care
- ☐ Mitral Valve Prolapse
- ☐ Organ Transplant
- ☐ Pacemaker/Internal Defibrillator
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures/ Epilepsy
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea/ C-PAP use
- ☐ *Stroke/TIA (when?)_____
- ☐ Thyroid Problems
- ☐ TB /Tuberculosis
- ☐ Ulcers/Stomach/Intestinal Problems

Signature _____ **Date** _____