

Medical History 2018 with Dental History(Copy)(Copy)

Patient Name:

Birth Date:

Date Created:

Dental History: Place a check mark if you have or have had any of the following:

Bleeding gums	<input type="radio"/> Yes <input type="radio"/> No	Grinding teeth	<input type="radio"/> Yes <input type="radio"/> No	Sensitivity to sweets	<input type="radio"/> Yes <input type="radio"/> No
Gums swollen or tender	<input type="radio"/> Yes <input type="radio"/> No	Lip or cheek biting	<input type="radio"/> Yes <input type="radio"/> No	Orthodontic treatment	<input type="radio"/> Yes <input type="radio"/> No
Dry Mouth	<input type="radio"/> Yes <input type="radio"/> No	Loose teeth or broken fillings	<input type="radio"/> Yes <input type="radio"/> No	Periodontal treatments	<input type="radio"/> Yes <input type="radio"/> No
Fingernail biting	<input type="radio"/> Yes <input type="radio"/> No	Sensitivity to cold/heat/biting	<input type="radio"/> Yes <input type="radio"/> No	Food collection between teeth	<input type="radio"/> Yes <input type="radio"/> No

How often do you brush? Comment

How often do you floss? Comment

Are you under a Physician's care? If yes, name of Physician. Yes No If yes

Have you ever been hospitalized, had a major operation or blood transfusions? If yes, approximate date. Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Have you ever had heart valve, or artificial joint replacement? If yes, approximate date. Yes No If yes

Do you currently have a health condition that requires premedication(antibiotic)prior to dental procedures? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Penicillin Codeine Acrylic Metal
 Latex Sulfa Drugs Local Anesthetics

Other? If yes

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Arthritis/Rheumatism	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No
Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Heart Attach/Failure	<input type="radio"/> Yes <input type="radio"/> No	Respiratory Disease	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy/Radiation	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No
Shingles	<input type="radio"/> Yes <input type="radio"/> No	Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	STD	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis A, B or C	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Tobacco Habit	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Back Problems	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Blood Disease	<input type="radio"/> Yes <input type="radio"/> No
Dementia	<input type="radio"/> Yes <input type="radio"/> No	Anemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	Circulatory Problem	<input type="radio"/> Yes <input type="radio"/> No
Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Jaw Pain/Problem	<input type="radio"/> Yes <input type="radio"/> No				

Have you ever had any serious illness not listed above? Yes No If yes

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent or Guardian:

X Date: _____