



Medical History

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List any medications that you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any of the following?

Y N

- Anesthetic
- Aspirin
- Codeine
- Ibuprofen

Y N

- Iodine
- Latex
- Penicillin
- Sulfa

Other Allergies: _____

Do you have any of the following medical conditions?

Y N

- Asthma
- Abnormal Bleeding
- Cancer
- Diabetes Type I or II
- Heart Attack
- Heart Trouble
- High Blood Pressure
- Joint Replacement
- Hyperthyroidism
- Anemia
- Dementia/Alzheimer's
- Fever Blisters/Cold Sores
- Epilepsy/Seizures/Fainting Spells
- Pacemaker
- Hepatitis A/B/C
- HIV/AIDS
- Head/Neck Radiation Treatment
- Anorexia/Bulimia
- Acid Reflux/Persistent Heartburn

Y N

- Kidney Disease
- Liver Disease
- Pregnant/Nursing
- Depression/Anxiety
- Sinus Trouble
- Stroke
- Ulcers
- Drug/Alcohol Abuse
- Hypothyroidism
- Severe/Frequent Headaches/Migraines
- Tuberculosis
- Snoring
- Sleep Apnea
- Glaucoma
- Macular Degeneration
- Blood Transfusion
- Transplant
- Heart Valve Replacement
- Do you require an antibiotic for dental work?

Past surgical history: _____



Dental History

Y N

- Do you require antibiotics before dental treatment?
- Do you have dry mouth?
- Do your gums bleed?
- Have you ever had periodontal (gum) treatment?
- Have you ever had orthodontic (braces) treatment?
- Have you ever participated in a sleep study?
- Have you ever been treated for TMJ problems?
- Do you smoke or use tobacco?
- Have you ever taken Fosamax, Actonel, or Boniva?

Date of last functional bite: _____

How many times per day do you brush your teeth? _____

How many times a week do you floss your teeth? _____

Have you ever had an unusual reaction to dental injections? _____

Has anyone ever told you that you grind your teeth? _____

Do you have any history of dental anxiety? _____

Is there anything you could like to change about your smile? _____

Is there anything else you think we should know that hasn't been addressed? _____

Signature of Patient, Parent, or Guardian

Date