

MEDICAL HISTORY

Name _____

Birth date _____

Please circle any of the following which you have or have had in the past

Do you require antibiotics before dental treatment? Y N

PRE-MED DOSEAGE _____

Y N Heart Conditions (Murmur, Rheumatic heart disease, Congenital defect, Mitral Valve Prolapse, Coronary artery disease, Irregular heart beat, Congestive heart failure) , Heart Attack or other _____

Y N Pregnant or breast-feeding currently (Women only)

Y N Are you past Menopause (Women only)

Y N Glaucoma

Y N Chest Pain (Angina)

Y N Thyroid Disease

Y N Heart Procedures – Stents, Catheterization, Angioplasty, Pacemaker, Bypass surgery, Prosthetic valve placement.

Y N Liver Disease (Cirrhosis, Hepatitis, Etc)

Type and Date of surgery _____

Y N Respiratory (Lung) Disease (Emphysema, Asthma, COPD, Tuberculosis, etc)

Y N Cortisone or steroid type medications

Y N Prosthetic joints or valves (Hip replacements, etc)
Type/Date _____

Y N Stroke / TIA's Date: _____

Y N Seizure Disorder (Epilepsy, traumatic)

Y N High Blood Pressure

Y N Arthritis (Rheumatoid, Osteo, Fibromyalgia, Gout)

Y N Blood Transfusions- Date _____

Y N Allergies (hay fever, foods, materials, or medications)

Y N Blood disorders (anemia, bleeding tendencies, etc)

Y N Stomach or Intestinal disease (GERD, Ulcers, Colitis, Diverticulitis, Hernia, Hiatal hernia)

Y N Sinus Problems

Y N Diabetes (or family history of)

Date Diagnosed _____

Y N Loss of Weight (without dieting)

Glucose level _____

Y N History of Surgery, especially several repeated Procedures in childhood

Y N Cancer, Tumors, or Growths (include skin, benign etc)
Type diagnosed _____

Y N Are you allergic to or unable to eat bananas, kiwis, avocados, chestnuts, tomatoes, potatoes, or hazelnuts?

Treatment _____

Y N Radiation therapy (X-ray treatments for Cancer)

Y N Do you have a heavy persistent cough of 2-3 weeks duration, particularly one that brings up sputum or bloodied sputum?

Area of Treatment _____

Dose amount _____

Y N Infectious disease (AIDS, HIV, Herpes, Syphilis, Tuberculosis, Hepatitis A, B, or C or other)

Y N Chemotherapy Treatment for Cancer

Date of Treatment _____

Y N Substance abuse (alcohol, cocaine, drugs, etc)

Length of Treatment _____

Y N Do you take or have you **ever** taken any of the

Y N Fainting spells / Vertigo

following: If yes for how Long? _____

Y N Frequent headaches or earaches

Fosamax or Fosamax plus D (Alendronate),

Y N TMJ (Jaw joint) problems or limited opening of mouth

Appliance? _____

Actonel (Risedronate), Boniva (Ibandronate)

Y N Organ Transplant _____

Date of Transplant: _____

Zometa (Zoledronic acid), Didronel (Etidronate

Y N Kidney Disease / Stones

disodium) Didrocal, Aredia (Pamidronate), Bonafos

Y N Autoimmune disease such as Lupus, Pemphigus, Pemphigoid, Lichen Planus

(Clondronate), Skelid (Tiludronate), Forteo

(Teriparatide)

Y N Other _____

Have you experienced an allergic or unusual reaction to any of the following?

___ Aspirin

___ Sulfa drugs

___ Penicillin

___ Erythromycin

___ Tetracycline

___ Barbiturates

___ Pain medication

___ Acetaminophen

___ Ibuprofen

___ Latex

___ Local anesthetic (Novocain)

___ Codeine

Please list any other drugs or materials that you are allergic to: _____

Name _____

Date _____

DENTAL HISTORY

- Y N Did you visit your dentist within the last year?
How often do you have your teeth cleaned? _____
Last cleaning date _____
- Y N Are you dissatisfied with the appearance of your teeth?
- Y N Are you worried about having dental treatment?
- Y N Would it bother you to lose your teeth?
- Y N Would you be tremendously disturbed if you had to wear artificial teeth?
- Y N Do your gums bleed easily?
- Y N Do your gums feel tender?
- Y N Does your mouth feel dry?
- Y N Do you have difficulty swallowing?
- Y N Do you clench or grind your teeth during the day or night?
- Y N Do your teeth feel loose?
- Y N Does your lower jaw click, snap, pop, or jump when you open?
- Y N Are your teeth sensitive to hot, cold, or sweets?
- Y N Do you use an electric Toothbrush? Brand _____
- Y N Have you ever had orthodontic treatment? Date _____
- Y N Have you ever had periodontal treatment? Date _____
Type – _____
Areas Treated _____
- Y N Are you on any special diet? Explain _____
- Y N Do you use tobacco in any form? Type _____
How Long ? _____

Special Considerations
Office Use Only