Medical & Dental History

Obtaining a complete medical history is vitally important as it affects your dental and overall health, wellness and longevity. It could also make a difference in what we determine to be the best course of treatment for you. Thank you for taking the time to carefully complete this form so that we are able to provide you with optimal, comprehensive & complete care.

Patient Name: ____ **DOB:** ______________________

Heart Concerns* ( ) Yes ( ) No
Heart Disease/Attack* ( ) Yes ( ) No
Heart Murmur ( ) Yes ( ) No
High Blood Pressure* ( ) Yes ( ) No
Low Blood Pressure ( ) Yes ( ) No
Mitral Valve Prolapse ( ) Yes ( ) No
Artificial Heart Valve ( ) Yes ( ) No
Pacemaker ( ) Yes ( ) No
Rheumatic Fever ( ) Yes ( ) No
Stroke* ( ) Yes ( ) No
PRE-MEDICATION Required? ( ) Yes ( ) No

Periodontal (gum) disease & dental infections may increase your risk for heart attack, stroke. and other serious cardiac concerns.

Anemia ( ) Yes ( ) No
Bleeding Disorder ( ) Yes ( ) No
Coumadin/Blood Thinners ( ) Yes ( ) No
Sickle Cell Disease ( ) Yes ( ) No
Liver Disease/Jaundice ( ) Yes ( ) No
Hepatitis ( ) Yes ( ) No

Type I/II Diabetes* ( ) Yes ( ) No
Last HbA1c Date & Score: ____________________

Studies show a strong correlation between diabetes and periodontal disease. It is important that both diseases are managed & well controlled. Warning signs of diabetes are frequent trips to the restroom, excessive and always feeling hungry.

History or Current Smoker/Tobacco ( ) Yes ( ) No
Recreational/Street Drugs ( ) Yes ( ) No
Have you ever worn braces? ( ) Yes ( ) No

Do you regularly use the following?
Toothbrush ( ) Yes ( ) No
Dental Floss ( ) Yes ( ) No
Mouth Rinse ( ) Yes ( ) No
Water Pik or Irrigator ( ) Yes ( ) No

Asthma ( ) Yes ( ) No
Sinus Problems ( ) Yes ( ) No
Seasonal Allergies ( ) Yes ( ) No
Mouth Breather ( ) Yes ( ) No
Snoring ( ) Yes ( ) No
Sleep Apnea* ( ) Yes ( ) No
If so, do you wear a CPAP?_____________

Cancer* ( ) Yes ( ) No
Radiation/Chemotherapy ( ) Yes ( ) No
Artificial Joints ( ) Yes ( ) No
Kidney Disease ( ) Yes ( ) No
Epilepsy/Seizures ( ) Yes ( ) No
AIDS/HIV ( ) Yes ( ) No
HPV ( ) Yes ( ) No
Neurological Disorders ( ) Yes ( ) No
Thyroid Disorder ( ) Yes ( ) No
Any Special Accommodations Needed? _______________

Psychiatric/Psychological ( ) Yes ( ) No
Headaches ( ) Yes ( ) No
Dizziness ( ) Yes ( ) No
Daytime Sleepiness ( ) Yes ( ) No
Weight Gain or Trouble Losing Weight ( ) Yes ( ) No
Jaw Clicking/Popping ( ) Yes ( ) No
Limited Opening of Jaw ( ) Yes ( ) No
Clenching/Grinding ( ) Yes ( ) No
Difficulty Swallowing ( ) Yes ( ) No
Gagging/Gasping ( ) Yes ( ) No
Breath Odor ( ) Yes ( ) No
Loose/Sensitive Teeth ( ) Yes ( ) No

For Women:
Currently Pregnant ( ) Yes ( ) No
Currently Nursing ( ) Yes ( ) No

Pregnant women with periodontal disease may have up to 7 X increased risk for having a pre-term, low birth weight baby.

How often do you brush? ______________________
Bleeding Gums ( ) Yes ( ) No

Allergies to medication(s), latex, or any substance? ( ) Yes ( ) No List: ________________________________
Do you take any medication(s) or prescriptions? ( ) Yes ( ) No List: ________________________________
Do you use any supplements or herbs? ( ) Yes ( ) No List: ________________________________

Feel free to use the back of this page if you need more room to list any of your allergies, medications or supplements

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*Please provide any **relevant family history** for any *starred items from* above: ____

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Patient Signature: ____ **Date:** ______________________