ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

# Patient Dental & Medical Health History Information

**To our patients:** Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

## PATIENT INFORMATION

Last Name: First Name: Middle Name:

Home Phone: Cell Phone: Work Phone:

Email Address:

Mailing Address: City: State: Zip:

Date of Birth: / / Gender:

Occupation:

Emergency Contact: Name: Relationship: Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____

If executing this form as the patient's personal representative. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

## DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

**Please mark an "X" in the box ONLY if this applies to you.**

Is it hard to open your mouth? ☐
Does it hurt to chew, bite or swallow? ☐
Do your gums bleed when you brush or floss your teeth? ☐
Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
Do you have, or have you ever had, any sores or growths in your mouth? ☐
Do you clench or grind your teeth? ☐
Does your jaw click, pop or hurt? ☐
Do you have earaches or neck pains? ☐
Does dental treatment make you nervous? ☐
Have you ever experienced any of these sleep-related breathing disorders? ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth? ☐
If yes, please describe what happened and when it happened: _____

Have you ever had problems with dental treatment in the past? ☐
If yes, please describe what happened: _____

Have you ever had a reaction to, or problem with, dental anesthesia? ☐
If yes, please describe what happened: _____

Are you unhappy with your smile? ☐
If yes, why? Please mark all that apply:
☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
☐ Other. Please describe: _____

## MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

**Please use an "X" to mark your answers to the following questions.** Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐
If yes, what medication are you taking? _____

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).
If yes, what medication are you taking? _____

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).
If yes, what medication are you taking? _____ How many years have you been taking it? _____

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? _____

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐
If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?** ☐ ☐ ☐
If yes, please list them here and include information about how much and how often you use each one. _____

**WOMEN ONLY:** Are you:

Taking **birth control pills**? ☐ ☐ ☐

**Pregnant**? If yes, number of weeks: _____ ☐ ☐ ☐

**Nursing**? If yes, number of weeks: _____ ☐ ☐ ☐


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## ALLERGIES Please use an "X" to mark your answers to the following questions.

**Are you allergic to or have you had an allergic reaction to:**

| | Yes | No | ? |
|---|---|---|---|
| Aspirin | ☐ | ☐ | ☐ |
| Barbiturates, sedatives or sleeping pills | ☐ | ☐ | ☐ |
| Codeine or other narcotics | ☐ | ☐ | ☐ |
| Hay fever/seasonal allergies | ☐ | ☐ | ☐ |
| Iodine | ☐ | ☐ | ☐ |
| Latex (rubber) | ☐ | ☐ | ☐ |
| Local anesthetics | ☐ | ☐ | ☐ |
| Metals | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics | ☐ | ☐ | ☐ |
| Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix) | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ |

Please describe any "Yes" answers and include information about your experience.

_____

## MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

**Please use an "X" to mark your answers to the following questions.**

| | Yes | No | ? |
|---|---|---|---|
| Are you in good physical health? | ☐ | ☐ | ☐ |
| Are you currently being seen or treated by a physician? | ☐ | ☐ | ☐ |
| Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done? | ☐ | ☐ | ☐ |
| Have you had a **serious illness, operation or been hospitalized** in the past 5 years? | ☐ | ☐ | ☐ |
| Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)? | ☐ | ☐ | ☐ |
| Have you had a **heart valve replacement or heart surgery**? | ☐ | ☐ | ☐ |
| Have you had an **organ or bone marrow/stem cell transplant**? | ☐ | ☐ | ☐ |
| Have you traveled internationally within the last 30 days | ☐ | ☐ | ☐ |
| Have you had a fever (100.4°F or above) in the last 72 hours? | ☐ | ☐ | ☐ |

If you answered yes to any of the above, please explain: _____

## MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

**Do you have, or have you been diagnosed with, any of the following conditions?**

| | Yes | No | ? |
|---|---|---|---|
| **Heart (Cardiac) Health** | | | |
| Pacemaker/implanted defibrillator | ☐ | ☐ | ☐ |
| Artificial (prosthetic) heart valve | ☐ | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ | ☐ |
| Congenital heart disease (CHD) | ☐ | ☐ | ☐ |
| Unrepaired, cyanotic CHD | ☐ | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Coronary artery disease | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur/rhythm disorder | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| **Breathing (Respiratory) Health** | | | |
| Asthma (COPD) | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| **Cancer** | ☐ | ☐ | ☐ |
| Type: _____ | | | |
| Date of diagnosis: _____ | | | |
| Chemotherapy: _____ | | | |
| Radiation treatment: _____ | | | |
| **Blood (Circulatory) Health** | | | |
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date: _____ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| High or low blood pressure | ☐ | ☐ | ☐ |
| **Brain (Neurological)/Mental Health** | | | |
| Anxiety | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| Post-traumatic stress disorder | ☐ | ☐ | ☐ |
| Traumatic brain injury or concussion | ☐ | ☐ | ☐ |
| **Autoimmune Disease** | | | |
| AIDS or HIV Infection | ☐ | ☐ | ☐ |
| Lupus | ☐ | ☐ | ☐ |
| **Digestive Health** | | | |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. reflux/persistent heartburn (GERD) | ☐ | ☐ | ☐ |
| Stomach ulcers | ☐ | ☐ | ☐ |
| **Eye (Vision) Health** | | | |
| Glaucoma | ☐ | ☐ | ☐ |
| **Other** | | | |
| Arthritis | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes (type I or II) | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Frequent infections | ☐ | ☐ | ☐ |
| Type of infection: _____ | | | |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Immune deficiency | ☐ | ☐ | ☐ |
| Kidney problems | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Sexually transmitted infection (STI) | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

## MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

| **In the past 30 days, have you:** | Yes | No | ? |
|---|---|---|---|
| had pain or tightness in the chest? | ☐ | ☐ | ☐ |
| coughed up blood or had a cough that lasted longer than 3 weeks? | ☐ | ☐ | ☐ |
| been exposed to anyone with tuberculosis? | ☐ | ☐ | ☐ |
| had a rapid or irregular heart beat? | ☐ | ☐ | ☐ |
| found it hard to catch your breath? | ☐ | ☐ | ☐ |
| had a high fever (greater than 101.5°F) for no reason? | ☐ | ☐ | ☐ |
| noticed a change in your vision? | ☐ | ☐ | ☐ |
| fainted for no reason? | ☐ | ☐ | ☐ |
| experienced vomiting, diarrhea, chills, night sweats or bleeding? | ☐ | ☐ | ☐ |
| had migraines or severe headaches? | ☐ | ☐ | ☐ |

**NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.**
I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

## FOR COMPLETION BY DENTIST

Comments: _____

**Office Use Only:** ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____


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