

Medical & Dental History Form

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: _____-____-____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

Emergency Contact Name: _____

Emergency Contact Phone: _____

Referred By: _____

Most preferred method of communication for confirming your appointment:

Home Phone Message Email Text Message Cell Phone message

DENTAL HISTORY

Are you having any dental discomfort at this time? Yes No

Have you ever been treated for gum disease? Yes No

Family history of gum disease: Yes No

Have you ever been treated by an orthodontist? Yes No

Do you feel you clench or grind your teeth? Yes No

Do you have or wear a Night Guard/ Retainer/Snore Guard? Yes No

Do you have jaw joint pain? (TMJ) Yes No

MEDICAL HISTORY

Do You Need to take Antibiotics for any of the following conditions prior to your dental visit?

Congenital heart disease/defect? Yes No

Damaged or artificial heart valves? Yes No

Artificial joint replacement?
 Yes No

Which Joint and Date of replacement: _____

How long after your joint replacement does your surgeon want you to be premedicated? _____

Have you ever taken a bone enhancing drug for osteoporosis or chemotherapy?
When? Yes No

Have you ever had head and neck radiation for cancer treatment? Yes No

Have you had the Human Papillomavirus (HPV) vaccine? Yes No

List any drug allergies:

List any medications you are currently taking (including vitamins, herbal supplements):

Have you been hospitalized since your last visit? _____

Please indicate if any of the following apply to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Alzheimers/Dementia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Arthritis (Osteo/Rheumatoid) | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer: Chemo/Radiation |
| <input type="checkbox"/> Diabetes (Type I, Type II) | <input type="checkbox"/> Depression | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Environmental Allergies | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Special Needs/Disabilities | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> By-Pass Surgery | <input type="checkbox"/> Heart Arrhythmia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heart Murmur/ Mitral Valve Prolapse | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis (A, B, C, D) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers/Digestive | <input type="checkbox"/> Allergy to Latex |
| <input type="checkbox"/> Allergy to Amoxicillin | <input type="checkbox"/> Allergy to Sulfa Drugs | <input type="checkbox"/> Sensitivity to Epinephrine |
| <input type="checkbox"/> Tobacco Use Present | <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Are You Pregnant? |
| <input type="checkbox"/> Tobacco Use Past | <input type="checkbox"/> Vaping Use | |

Do you have any other conditions not listed?

Signature of Patient, Parent or Guardian:

Signature _____ Date _____

Response Date: ____/____/____