

Patient Name: _____ Date: _____

6 Medical History

Name of Personal Physician: _____
Address/Clinic: _____ Phone #: _____
Date of Last Visit to Any Physician: _____
Reason for That Visit: _____

List any prescription or over-the-counter medications he/she is currently taking (including herbal supplements) and dosages: _____

Is he/she allergic to any of the following? Please check yes or no for each.

- | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------|
| YES | NO | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | YES | NO | <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| | | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food Allergies |

If you are aware of any adverse reactions to other medications, he/she has had list them here: _____

Does he/she take antibiotic premedication for dental appointments?: _____

Has he/she ever had any of the following diseases or medical problems? Please check yes or no for each item.

- | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------|
| YES | NO | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding | YES | NO | <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or Drug Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Bones | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of Endocarditis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Valve Replacement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Other medical notes: _____

Does he/she use tobacco in any form? Yes No
If so, what form? Chewing Tobacco Cigarettes
Are you taking any medications for Osteoporosis? Yes No

FEMALES

Is she taking Birth Control Pills/Patch/Injections? Yes No
Is she pregnant? Yes No Is she nursing? Yes No

7 Dental History

Has he/she ever had any serious/difficult problems with dental treatment? Yes No
If yes, please explain: _____

Do his/her gums ever bleed? Yes No

Has he/she ever had:

- | | | |
|---------------------------------------|------------------------------|-----------------------------|
| Orthodontic Treatment (Braces) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Oral Surgery (Extractions) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Periodontal Treatment (Gum Disease) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A bite splint or mouth guard | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A serious injury to the mouth or head | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Does he/she experience:

- | | | |
|----------------------------------|------------------------------|-----------------------------|
| Clicking or popping of the jaw | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches, neck or shoulder pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

How many times a week does he/she floss? _____

How many times a day does he/she brush? _____

Do you assist him/her with brushing? Yes No

Other than toothpaste, does he/she take supplemental fluoride in any form? Yes No

8 Dental Future

What is the reason for today's visit? _____

Is he/she currently in pain? Yes No

What would you change about his/her smile or bite, if you could? _____

Would he/she like whiter teeth? Yes No
Would he/she like fresher breath? Yes No

I understand the information I have given today is correct to the best of my knowledge. I also understand and accept my responsibility to inform this office of any changes in my/my child's medical status.

Parent's or Guardian's Signature: _____ Date _____

Medical History Update

I have read my medical history information and confirm it states past and present medical conditions:

Date: _____ No changes Changes—please explain: _____

Signature: _____

Date: _____ No changes Changes—please explain: _____

Signature: _____

Date: _____ No changes Changes—please explain: _____

Signature: _____