Medical History 2018 with Dental History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Dental History: Place a check mark if you have or have had any of the following:

Bleeding gums	Yes No	Grinding teeth	Yes No	Sensitivity to sweets	Yes No
Gums swollen or tender	Yes No	Lip or cheek biting	Yes No	Orthodontic treatment	Yes No
Dry Mouth	Yes No	Loose teeth or broken fillings	Yes No	Periodontal treatments	Yes No
Fingernail biting	Yes No	Sensitivity to cold/heat/biting	Yes No	Food collection between teeth	Yes No

How often do you brush? Comment

How often do you floss? Comment

Are you under a Physician's care? If yes, name of Physician.	Yes No	If yes
Have you ever been hospitalized, had a major operation or blood transfusions? If yes, approximate date.	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Have you ever had heart valve, or artificial joint replacement? If yes, approximate date.	Yes No	If yes
Do you currently have a health condition that requires premedication(antibotic)prior to dental procedures?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal

☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Diabetes	Yes No	High Cholesterol	Yes No	Alzheimer's Disease	Yes No
Emphysema	Yes No	Kidney Problems	Yes No	Arthritis/Rheumatism	Yes No	Epilepsy or Seizures	Yes No
Liver Disease	Yes No	Artificial Heart Valve	Yes No	Glaucoma	Yes No	Mitral Valve Prolapse	Yes No
Asthma	Yes No	Headaches	Yes No	Osteoporosis	Yes No	Cancer	Yes No
Heart Attach/Failure	Yes No	Respiratory Disease	Yes No	Chemotherapy/Radiation	Yes No	Heart Murmur	Yes No
Shingles	Yes No	Chemical Dependency	Yes No	Heart Pacemaker	Yes No	STD	Yes No
Hepatitis A, B or C	Yes No	High Blood Pressure	Yes No	Tobacco Habit	Yes No	Thyroid Disease	Yes No
Tuberculosis	Yes No	Back Problems	Yes No	Excessive Bleeding	Yes No	Blood Disease	Yes No
Dementia	Yes No	Anemia	Yes No	Stroke	Yes No	Circulatory Problem	Yes No
Hemophilia	Yes No	Jaw Pain/Problem	Yes No				

Have you ever had any serious illness not listed above? Yes No If yes

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent or Guardian:

X Date:_____