Adult Dental and Medical Health History Form

PATIENT INFORMATION

First Name: Last 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 the 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

Are you currently experiencing any dental pain or discomfort? ☐Yes ☐No If yes, Where?
When was your last Dental Exam? / / Last time you had dental x-rays taken?

Please check any box that 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 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 dental anesthesia?............ ☐
If yes, please describe what happened: _________________
____
____

Are you unhappy with your smile?......................................☐
If yes, why? Please mark all that apply:
☐Color of your teeth ☐Shape of your teeth
☐Position of your teeth
☐Other: ____

MEDICATION & OTHER PRODUCTS/SUBSTANCES

Please check the box 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? ____
Last known INR: _________________ Date of last INR: ______/_____/______

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 (Prolina)
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 included denosumab (Xgeva), pamidronate (Aredia) or zolendronate (Zometa).
If yes, what medication are you taking? __________________________________ How many years have you been taking it?_____________

Yes No ?

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

Yes No ?

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)?........ ☐ ☐ ☐
Do you use **vaping products**? .... ☐ ☐ ☐
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 reasons(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? ☐Yes ☐No If yes, number of weeks: ______________ **Nursing?** ☐Yes ☐ No If yes, number of weeks: ______________

*****ALLERGIES*** (examples: Latex, Penicillin/Amoxicillin, Sulfa)........ ☐Yes ☐No

If yes, do you carry an epi pen: ☐ Yes ☐ No
*****Please list Allergies***: ____
____
____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / / What is your normal blood pressure (systolic, diastolic)?
Doctor's name: Phone:

Please check any box that applies to you: **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)?.... ☐ ☐ ☐
Have you had a **heart valve replacement or heart surgery**?........ ☐ ☐ ☐
Have you had an **organ or bone marrow/stem cell transplant**?........ ☐ ☐ ☐
If you answered yes to any of the above, please explain: ____

MEDICAL HISTORY SPECIFIC Please check the box that applies to you:

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 the last 6 mo ☐ ☐ ☐
Repaired CHD with residual defects........ ☐ ☐ ☐
Arteriosclerosis........ ☐ ☐ ☐
Coronary artery disease........ ☐ ☐ ☐
Congestive heart failure........ ☐ ☐ ☐
Damaged heart valves........ ☐ ☐ ☐
Heart attack........ ☐ ☐ ☐
Heart murmur/rhythm disorder........ ☐ ☐ ☐

Yes No ?

Cancer........ ☐ ☐ ☐
Type:___________________________
Date of Diagnosis:______________
Chemotherapy: _______________
Radiation Treatment: __________

Blood (Circulatory) Health
Anemia........ ☐ ☐ ☐
Blood transfusion........ ☐ ☐ ☐
If yes, date: ___________________
Hemophilia........ ☐ ☐ ☐
High or low blood pressure.. ☐ ☐ ☐

Yes No ?

Brain (Neurological)/Mental Health

Yes No ?

Digestive Health
Gastrointestinal disease........ ☐ ☐ ☐
G.E. reflux/persistent heartburn (GERD)........ ☐ ☐ ☐
Stomach ulcers........ ☐ ☐ ☐

Other
Arthritis........ ☐ ☐ ☐
Chronic pain........ ☐ ☐ ☐
Diabetes (type I or II)........ ☐ ☐ ☐
Last known A1C:________________
Date of last A1C:_______________
Eating Disorder........ ☐ ☐ ☐
Frequent infections........ ☐ ☐ ☐
Type of infections: ________________
Hepatitis, jaundice or liver disease........ ☐ ☐ ☐
Immune deficiency........ ☐ ☐ ☐

Yes No ?

Rheumatic heart disease........ ☐ ☐ ☐

Anxiety........ ☐ ☐ ☐

Kidney problems........ ☐ ☐ ☐

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	Yes	No	?
Stroke	☐	☐	☐

Breathing (Respiratory) Heath

	Yes	No	?
Asthma (COPD)	☐	☐	☐

Date of last asthma attack: ______________

Do you carry a rescue inhaler? ☐ Yes ☐ No

Ever Hospitalized? ☐ Yes ☐ No

If yes, date: ___________________________

	Yes	No	?
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐

	Yes	No	?
Depression	☐	☐	☐
Epilepsy/seizures	☐	☐	☐

Date of last seizures:_____________

	Yes	No	?
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐

Autoimmune Disease

	Yes	No	?
AIDS or HIV infection	☐	☐	☐
Lupus	☐	☐	☐

Eye (Vision) Health

	Yes	No	?
Glaucoma	☐	☐	☐

	Yes	No	?
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid Problem	☐	☐	☐
Substance abuse	☐	☐	☐

Surgeries:

Type of surgery: _______________________

Date of surgery: _______________________

Type of surgery: _______________________

Date of surgery: _______________________

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

____

MEDICATIONS

Please List any medications, vitamins, or herbal supplements:

____

____

____

NOTE: **It's important for both the doctor and the 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:____

FOR COMPLETION BY DENTIST

Comments: ____

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