DENTAL

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DENTAL & MEDICAL INFORMATION

DENTAL HISTORY

Reason for today's visit? ❒Exam ❒Emergency ❒Consultation Are you in pain? ❒Yes ❒No How long?_____

Please indicate ☑any of the following problems:

❒Discomfort, clicking or popping in jaw	❒Lost/broken filling(s)	❒Stained teeth
❒Red, swollen or bleeding gums	❒Teeth grinding	❒Locking jaw
❒Sensitive tooth, teeth or gums	❒Ringing in ears	❒Bad breath
❒Blisters/sores in or around mouth	❒Broken/chipped tooth	

Other: _____

Do you require pre-medication? ❒Yes ❒No ❒Don't know

Are you allergic to any of the following? ❒Latex ❒Penicillin/Amoxicillin ❒Tetracycline ❒Aspirin ❒Dental Anesthetics

❒Foods _____ ❒Others _____

Do you use smoke, dip or vape tobacco ❒No ❒Yes/how used? _____ How much?_____How long?_____

For women:

Do you take birth control pills? ❒Yes ❒No Are you pregnant? ❒Yes ❒No If yes, how long?____ Are you nursing?❒Yes ❒No

What medications are you taking? ❒Nerve pills ❒Pain killers (including aspirin) ❒Muscle relaxers ❒Stimulants ❒Insulin ❒Blood thinners ❒Tranquilizers ❒Osteoporosis Medication ❒Other(s)_____

_____

Have you ever taken: Bisphosphonates (e.g. Aredia/Fosamax) ❒Yes ❒No Phen-fen/Redux ❒Yes ❒No

MEDICAL HISTORY

Do you have or have you had any of the following diseases, medical conditions or procedures?

❒Yes ❒No Heart attack/stroke	❒Yes ❒No Thyroid problems	❒Yes ❒No Cancer/tumors	❒Yes ❒No Cosmetic surgery
❒Yes ❒No Heart surgery/pacemaker	❒Yes ❒No Kidney problems	❒Yes ❒No Shingles	❒Yes ❒No Radiation/Cobalt treatment
❒Yes ❒No Heart murmur	❒Yes ❒No Liver problems	❒Yes ❒No Hepatitis	❒Yes ❒No Chemotherapy
❒Yes ❒No Rheumatic fever	❒Yes ❒No Respiratory problems	❒Yes ❒No HIV+/AIDS/ARC	❒Yes ❒No Asthma
❒Yes ❒No Mitral valve prolapse	❒Yes ❒No Sinus problems	❒Yes ❒No Arthritis/rheumatism	❒Yes ❒No Difficulty breathing
❒Yes ❒No Artificial valves	❒Yes ❒No Stomach problems/ulcers	❒Yes ❒No Artificial bones/joints	❒Yes ❒No Diabetes/hypoglycemia
❒Yes ❒No Heart disease	❒Yes ❒No Psychiatric problems	❒Yes ❒No Emphysema	❒Yes ❒No Leukemia
❒Yes ❒No Congenital heart defect	❒Yes ❒No Venereal disease	❒Yes ❒No Fainting/seizures/epilepsy	❒Yes ❒No Anemia
❒Yes ❒No Chest pains	❒Yes ❒No Alcohol/drug abuse	❒Yes ❒No Severe/frequent headaches	❒Yes ❒No High/low blood pressure
❒Yes ❒No Scarlet fever	❒Yes ❒No Tuberculosis TB	❒Yes ❒No Frequent neck pain	❒Yes ❒No Bleeding problems
❒Yes ❒No Nervousness	❒Yes ❒No Jaw problems TMD	❒Yes ❒No Back problems	❒Yes ❒No Glaucoma

❒Yes ❒No Sleep Apnea / Do you wear a device for Sleep Apnea?_____

Please list any other surgeries or medial conditions you have had _____

_____

Patient or Guardian Signature_____ Date _____

Reviewing Dentist Signature _____ Date _____