

MEDICAL HISTORY

Website Med Hx

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

ALLERGIES

Aspirin Local Anesthetics
 Codeine Penicillin/Amoxicillin
 Iodine Sulfa
 Latex Metals
 Acrylic Other: _____

MEDICATIONS

Please list medications you are currently taking: _____

 Pharmacy: _____

Please circle yes or no to indicate if you have or had any of the following:

BP
P

CARDIOVASCULAR problems	Yes	No	GENITOURINARY/HEPATIC Problems	Yes	No	PSYCHIATRIC Care	Yes	No
Angina/Chest Pains	Yes	No	Kidney Stones/Problems	Yes	No	Hallucination	Yes	No
High/Low Blood Pressure	Yes	No	Renal Dialysis	Yes	No	Depression	Yes	No
Heart Attack/Failure	Yes	No	Liver Disease	Yes	No	Suicidal Ideations	Yes	No
Stroke	Yes	No	Hepatitis A	Yes	No	SYSTEMIC DISEASES/OTHER	Yes	No
Artificial Heart Valve*	Yes	No	Hepatitis B, C, or other	Yes	No	Glaucoma	Yes	No
Cardiac Valve Repair*	Yes	No	SKIN Problems	Yes	No	Cancer	Yes	No
Cardiac Valvulopathy*	Yes	No	Tumors or Growths	Yes	No	Leukemia	Yes	No
Congenital Heart Disease**	Yes	No	Hives or Rash	Yes	No	Radiation Treatments	Yes	No
Infective Endocarditis*	Yes	No	Cold Sores or Fever Blisters	Yes	No	Chemotherapy	Yes	No
Heart Murmur	Yes	No	Herpes	Yes	No	BISPHOSPHONATE USE	Yes	No
Heart Pace Maker	Yes	No	IMMUNOLOGIC/BLOOD Problems	Yes	No	Actonel® (risendronate)	Yes	No
EAR/NOSE/THROAT problems	Yes	No	Abnormal bleeding/bruising	Yes	No	Aldendronate (Fosamax®)	Yes	No
Hearing Loss	Yes	No	Blood disease	Yes	No	Boniva® (ibandronate)	Yes	No
Sinus Trouble	Yes	No	Blood Transfusion	Yes	No	Etidronate (Didronel)	Yes	No
Tonsillitis	Yes	No	AIDS/HIV Positive	Yes	No	Pamidronate (Aredia®)	Yes	No
Chronic Cough	Yes	No	Anemia	Yes	No	Skelid® (tiludronate)	Yes	No
ENDOCRINE Problems	Yes	No	Anaphylaxis	Yes	No	Reclast® (zoledronic)	Yes	No
Thyroid disease/Problems	Yes	No	Hemophilia	Yes	No	Zometa® (zoledronic)	Yes	No
Diabetes	Yes	No	Sickle Cell Disease	Yes	No	DAILY ASPIRIN or IBUPROFEN	Yes	No
Parathyroid disease	Yes	No	MUSCULOSKELATAL Problems	Yes	No	SURGERIES or PAST HOSPITALIZATIONS	Yes	No
RESPIRATORY Problems	Yes	No	Arthritis/Gout	Yes	No	SERIOUS ILLNESS NOT LISTED	Yes	No
Asthma/shortness of breath	Yes	No	Hip/Knee/Joint Replacement	Yes	No	TOBACCO USE	Yes	No
COPD/Emphysema	Yes	No	Osteoporosis	Yes	No	ALCOHOL USE _____ drinks x _____	Yes	No
Tuberculosis (TB)	Yes	No	Joint Pain/Stiffness	Yes	No	WOMEN, are you:		
Lung Disease	Yes	No	NERVOUS SYSTEM Problems	Yes	No	Pregnant	Yes	No
Snoring/Sleep apnea	Yes	No	Epilepsy or Seizures	Yes	No	Nursing	Yes	No
GASTRO INTESTINAL Problems	Yes	No	Frequent Headaches	Yes	No	Taking Oral Contraceptives	Yes	No
GERD	Yes	No	Multiple Sclerosis	Yes	No			
Indigestion	Yes	No	Alzheimer's Syndrome	Yes	No			
Nausea/Vomiting	Yes	No	Parkinson's Disease	Yes	No			
Ulcers	Yes	No						

**Antibiotic premed not required for CHD except following: 1- Unrepaired cyanotic CHD with palliative shunts/conduits. 2- First 6 months after repaired defect with prosthetic material. 3- Repaired CHD with residual defect at or near site.

DENTAL HISTORY

Does anything bother you about your smile, teeth or gums?	Yes	No	Does dental treatment make you nervous?	Yes	No
Would you like to whiten your teeth?	Yes	No	If yes, circle: Slightly Moderately Extremely		
Do you have bad breath?	Yes	No	Do you have any of the problems below? Please circle all that apply:		
Have you been told you have gum problems?	Yes	No	Sensitivity to cold	Bad taste	
Have you been told you need to see a periodontist?	Yes	No	Sensitivity to hot	Loose teeth	
Do you have any growths or sores in or around your mouth?	Yes	No	Sensitivity to sweets	Swelling	
Does food collect between your teeth?	Yes	No	Sensitivity to biting/pressure	Bleeding Gums	
Do you have trouble chewing?	Yes	No			
Do you have any jaw joint pain?	Yes	No	How often do you brush? _____	Floss? _____	
Do you habitually clench or grind your teeth?	Yes	No			

What brings you to our office today? _____
 Date of last dental visit: _____ Name of former Dentist: _____ City, State: _____

What can we do to meet your expectations for exceptional dental care? _____

ACKNOWLEDGMENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

SIGNATURE OF PATIENT OR GUARDIAN: _____ DATE: _____

PROVIDER NOTES (DO NOT WRITE BELOW THIS LINE)

PROVIDER: _____

MEDICAL ALERTS

MISC ALERTS