2021

PATIENT NAME: _____

MEDICAL HISTORY — 2021 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**
Angina/Chest Pains	Yes	No
High/Low **Blood Pressure**	Yes	No
Heart Attack/Failure	Yes	No
Stroke	Yes	No
Artificial Heart Valve*	Yes	No
Cardiac Valve Repair*	Yes	No
Cardiac Valvulopathy*	Yes	No
Congenital Heart Disease**	Yes	No
Infective Endocarditis*	Yes	No
Heart Murmur	Yes	No
Heart Pace Maker	Yes	No
EAR/NOSE/THROAT problems	**Yes**	**No**
Hearing Loss	Yes	No
Sinus Trouble	Yes	No
Tonsillitis	Yes	No
Chronic Cough	Yes	No
ENDOCRINE Problems	**Yes**	**No**
Thyroid disease/Problems	Yes	No
Diabetes	Yes	No
Parathyroid disease	Yes	No
RESPIRATORY Problems	**Yes**	**No**
Asthma/shortness of breath	Yes	No
COPD/Emphysema	Yes	No
Tuberculosis (TB)	Yes	No
Lung Disease	Yes	No
Snoring/Sleep apnea	Yes	No
GASTRO INTESTINAL Problems	**Yes**	**No**
GERD	Yes	No
Indigestion	Yes	No
Nausea/Vomiting	Yes	No
Ulcers	Yes	No

GENITOURINARY/HEPATIC Problems	**Yes**	**No**
Kidney Stones/Problems	Yes	No
Renal Dialysis	Yes	No
Liver Disease	Yes	No
Hepatitis A	Yes	No
Hepatitis B, C, or other	Yes	No
SKIN Problems	**Yes**	**No**
Tumors or Growths	Yes	No
Hives or Rash	Yes	No
Cold Sores or Fever Blisters	Yes	No
Herpes	Yes	No
IMMUNOLOGIC/BLOOD Problems	**Yes**	**No**
Abnormal bleeding/bruising	Yes	No
Blood disease	Yes	No
Blood Transfusion	Yes	No
AIDS/HIV Positive	Yes	No
Anemia	Yes	No
Anaphylaxis	Yes	No
Hemophilia	Yes	No
Sickle Cell Disease	Yes	**No**
MUSCULOSKELATAL Problems	**Yes**	**No**
Arthritis/Gout	Yes	No
Hip/Knee/Joint Replacement	Yes	No
Osteoporosis	Yes	No
Joint Pain/Stiffness	Yes	No
NERVOUS SYSTEM Problems	**Yes**	**No**
Epilepsy or Seizures	Yes	No
Frequent Headaches	Yes	No
Multiple Sclerosis	Yes	No
Alzheimer's Syndrome	Yes	No
Parkinson's Disease	Yes	No

PSYCHIATRIC Care	**Yes**	**No**
Hallucination	Yes	No
Depression	Yes	No
Suicidal Ideations	Yes	No
SYSTEMIC DISEASES/OTHER	**Yes**	**No**
Glaucoma	Yes	No
Cancer	Yes	No
Leukemia	Yes	No
Radiation Treatments	Yes	No
Chemotherapy	Yes	No
BISPHOSPHONATE USE	**Yes**	**No**
Actonel® (risendronate)	Yes	No
Aldendronate (Fosamax ®)	Yes	No
Boniva ® (ibandronate)	Yes	No
Etidronate (Didronel)	Yes	No
Pamidronate (Aredia ®)	Yes	No
Skelid ® (tiludronate)	Yes	No
Reclast ® (zoledronic)	Yes	No
Zometa ® (zoledronic)	Yes	No
DAILY ASPIRIN or IBUPROFEN	**Yes**	**No**
SURGERIES or PAST HOSPITALIZATIONS	**Yes**	**No**
SERIOUS ILLNESS NOT LISTED	**Yes**	**No**
TOBACCO USE	**Yes**	**No**
ALCOHOL USE ____drinks x _____	**Yes**	**No**
WOMEN, are you:		
Pregnant	Yes	No
Nursing	Yes	No
Taking Oral Contraceptives	Yes	No

**Antibiotic premedication may be required prior to your appointment.*

***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
Would you like to whiten your teeth?	Yes	No
Do you have bad breath?	Yes	No
Have you been told you have gum problems?	Yes	No
Have you been told you need to see a periodontist?	Yes	No
Do you have any growths or sores in or around your mouth?	Yes	No
Does food collect between your teeth?	Yes	No
Do you have trouble chewing?	Yes	No
Do you have any jaw joint pain?	Yes	No
Do you habitually clench or grind your teeth?	Yes	No

Does dental treatment make you nervous? Yes No

If yes, circle: Slightly Moderately Extremely

Do you have any of the problems below? Please circle all that apply:

Sensitivity to cold	Bad taste
Sensitivity to hot	Loose teeth
Sensitivity to sweets	Swelling
Sensitivity to biting/pressure	Bleeding Gums

How often do you brush?_____ Floss? _____

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:_____

MISC ALERTS

MEDICAL ALERTS

2021