Medical/Dental History

Name: ______________________________________ Sex: [ ] Male [ ] Female [ ] Gender Neutral

Address: ____

Date of Birth: _______________________ Age: _______

Race: [ ] Asian [ ] Black [ ] Latino/a [ ] Native American [ ] White [ ] Other______________________

Circle the appropriate answer. If you don't know the correct answer, please write "Don't Know" after the question.

1. Physician Name _____________________________________ Telephone:_________________________
2. Are you under a physician's care?...YES NO
   Since When? ______________________ Why? ____
3. When was your last complete physical exam? ____
4. Current Medications (Include Over-the-Counter and Herbal Supplements):

Medication	Frequency	Medication	Frequency

5. Are you allergic to any Medications, or Substances?...YES NO
   If YES, Please list ____
   ____
6. Are you allergic to any Metals, Latex, or Anesthetics?..YES NO
   If YES, Please list ____
7. WOMEN ONLY: Are you pregnant or suspect you may be?...YES NO
8. WOMEN ONLY: Do you use any birth control medications?..YES NO
9. Have you ever been treated for or told you might have heart disease?..YES NO
10. Do you have a PACEMAKER or an ARTIFICIAL HEART VALVE IMPLANT? (please circle) ....YES NO
11. Have you ever had rheumatic fever?...YES NO
12. Are you aware of any heart murmurs?...YES NO
13. Do you have HIGH or LOW blood pressure? (please circle) ....YES NO

14. Have you ever had a serious illness or major surgery?..YES NO
    If so, please explain ____
    ____

15. Have you ever had radiation treatment and/or chemo treatment for tumor growth or other condition?..YES NO
    If so, please explain ____
16. Have you ever taken Fosamax, Zometa, Aredia, or any other oral or intravenous treatment for bone tumors, excessive calcium in your blood, or osteoporosis?...YES NO
17. Do you have inflammatory diseases, such as arthritis or rheumatism?...YES NO
18. Do you have any artificial joints/prosthesis?..YES NO
    If so, list joint and date inserted____
19. Do you have any blood disorders, such as anemia, leukemia, etc.?...YES NO
20. Have you ever bled excessively after being cut or injured?...YES NO
21. Are you on any blood thinners?..YES NO
    If so, what medication? ____
22. Do you have any stomach problems?..YES NO
23. Do you have any kidney problems?..YES NO
24. Do you have any liver problems?..YES NO
25. Are you diabetic?..YES NO
26. Do you have fainting or dizzy spells?...YES NO
27. Do you have asthma?..YES NO
28. Do you have epilepsy or seizure disorders?..YES NO
29. Do you have or have you had venereal or any sexually transmitted disease?.................................YES NO
30. Have you tested HIV positive?...YES NO
31. Do you have AIDS?...YES NO
32. Have you had or do you test positive for hepatitis?..YES NO
33. Do you or have you had Tuberculosis (T.B.)?...YES NO
34. Do you smoke, chew, use snuff, e-cigarettes, or any other forms of tobacco or nicotine?..............YES NO
35. Do you regularly consume more than 1 or 2 alcoholic beverages a day?..YES NO
36. Do you regularly use controlled substances?...YES NO
37. Have you had psychiatric treatment?...YES NO
38. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?...YES NO
39. Do you have any disease condition or problem not listed?...YES NO
    If so, please explain ____
40. Is there anything else we should know about your health that we have not covered?..................YES NO
    If so, please explain ____
41. Would you like to speak to the Doctor privately about any problem?..YES NO

IMMUNIZATIONS: (please list date given if known)

MMR		Influenza	
Polio		Pneumonia	
Hepatitis B		Tetanus <10	
DTaP			

42. How long since your last dental visit? ____
43. When was the last time your teeth were cleaned? ____
44. Have you seen a dentist regularly?...YES NO
    If YES, how often: ____
45. Have you lost any teeth or have any teeth been removed?..YES NO
46. Have they been replaced?...YES NO
47. How have they been replaced?
    a. Fixed bridge ______________________________ Age ______________________
    b. Removable bridge __________________________ Age ______________________
    c. Denture __________________________________ Age ______________________
    d. Implant __________________________________ Age ______________________
48. Have you had any problems or complications with previous dental treatment?............................YES NO
    If YES, explain: ____
    ____
49. Do you clench or grind your teeth?..YES NO
50. Does food get caught in your teeth?...YES NO
51. Are any of your teeth sensitive to: [ ] Hot [ ] Cold [ ] Sweets [ ] Pressure
52. Do your gums bleed or hurt?...YES NO
53. Do you experience dry mouth?..YES NO
54. How often do you brush your teeth? ________________________
55. How often do you floss? __________________________________
56. Are any of your teeth loose?..YES NO
57. Are any of your teeth chipped or broken?..YES NO
58. Are you happy with the appearance of your teeth?..YES NO
59. How do you feel about your teeth in general? ____
60. Do you feel your breath is offensive at times?...YES NO
61. Have you ever had gum treatment or surgery? ....YES NO
62. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ____
    ____
63. Do you have any questions or concerns?...YES NO
    If so, what? ____
    ____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ________________________________ **DATE** ______________

PROVIDER'S SIGNATURE ____ DATE ______________