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Medical & Dental History Form

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ______________________ ______________________ ___ ____________________
Last First M Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ___________ **SS#:** ___-__-____ **Prev. Visit:** ___________

Email Address: ____ **Best time to call:** ____________________

Phone: ___________ ___________ ___________ ______ ___________ ___________
Home Mobile Work Ext Fax Other

Address: ____ ____
Address 1 Address 2

____ ______ _____-____
City State Zip Code

Referred By: ____________________

Most preferred method of communication for confirming your appointment:
☐ Home Phone Message ☐ Email ☐ Text Message ☐ Cell Phone message

DENTAL HISTORY

Are you having any dental discomfort at this time? ◯ Yes ◯ No

Have you ever been treated for gum disease? ◯ Yes ◯ No

Family history of gum disease: ◯ Yes ◯ No

Have you ever been treated by an orthodontist? ◯ Yes ◯ No

Do you feel you clench or grind your teeth? ◯ Yes ◯ No

Do you have or wear a Night Guard/ Retainer/Snore Guard? ◯ Yes ◯ No

Do you have jaw joint pain? (TMJ) ◯ Yes ◯ No

MEDICAL HISTORY

Has your Physician/ Surgeon ever recommend that you take antibiotics for any of the following conditions?

Congenital heart disease/defect? ◯ Yes ◯ No

Damaged or artificial heart valves? ◯ Yes ◯ No

Artificial joint replacement? ◯ Yes ◯ No

Which Joint and Date of replacement: ____________________

Have you ever taken a bone enhancing drug for osteoporosis or chemotherapy?
When? ◯ Yes ◯ No

Have you ever had head and neck radiation for cancer treatment? ◯ Yes ◯ No

List any drug allergies:

___

___

List any medications you are currently taking (including vitamins, herbal supplements):

___

___

Have you been hospitalized since your last visit? ____________________

Please indicate if any of the following apply to you:

- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Alzheimers/Dementia
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (Osteo/Rheumotoid)
- ☐ Artifical Joints
- ☐ Asthma
- ☐ Auto Immune Disease
- ☐ Blood Disease
- ☐ Cancer: Chemo/Radiation
- ☐ Diabetes (Type I, Type II)
- ☐ Depression
- ☐ Eating Disorders
- ☐ Environmental Allergies
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Special Needs/Disabilities
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ By-Pass Surgery
- ☐ Heart Arrhythmia
- ☐ Angina
- ☐ Heart Murmur/ Mitral Valve Prolapse
- ☐ Heart Disease
- ☐ Hepatitis (A, B, C, D)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Diseases
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers/Digestive
- ☐ Allergy to Latex
- ☐ Allergy to Amoxicillin
- ☐ Allergy to Sulfa Drugs
- ☐ Sensitivity to Epinephrine
- ☐ Tobacco Use/Past, Present
- ☐ Alcohol/Drug Use
- ☐ Are You Pregnant?

Do you have any other conditions not listed?

___

___

Signature of Patient

Signature ______________________________ **Date** __________

Response Date: ____/____/________