Update of Dental/Medical History

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Telephone home: **(___) - ___ - ____** Date of last visit: __/__/____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / Over-the-counter drugs? ☐ Yes ☐ No

Please explain: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Do you wear a cardiac pacemaker, or have you had heart surgery? ☐ Yes ☐ No

When? __/__/____

Are you required to take any medication before your dental visit? ☐ Yes ☐ No

What? _____

For women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____ Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Yes/No		Yes/No	
☐	Abnormal Bleeding / Hemophilia	☐	Herpes / Fever blisters
☐	AIDS related complex	☐	High blood pressure
☐	Alcohol / Drug abuse	☐	Allergies or Hives
☐	Anemia	☐	Hospitalized for any reason
☐	Arthritis	☐	Kidney disease
☐	Artificial bones / Joints / Valves	☐	Liver disease
☐	Asthma	☐	Low blood pressure
☐	Blood transfusion	☐	Lupus
☐	Chemotherapy (Center, leukemia)	☐	Mitral valve prolapse
☐	Colitis	☐	Pacemaker
☐	Congenital heart defect	☐	Psychiatric problems
☐	Diabetes	☐	Radiation treatment
☐	Difficulty breathing	☐	Rheumatic / Scarlet fever
☐	Emphysema	☐	Shingles
☐	Epilepsy / seizures	☐	Sickle cell disease / Traits
☐	Fainting spells / seizures	☐	Sinus problems
☐	Frequent headaches	☐	Stroke
☐	Glaucoma	☐	Thyroid problems
☐	Hay fever	☐	Tuberculosis (TB)
☐	Heart attack / Surgery	☐	Ulcers
☐	Heart murmur	☐	Venereal disease
☐	Hepatitis / Jaundice	☐	Tumors or growths
☐	Excessive bleeding	☐	Tonsillitis
☐	Respiratory disease	☐	Head injuries
☐	Artifical prosthesis	☐	Heart failure
☐	Congenital heart disease	☐	Chicken pox
☐	X-Ray or cobalt treatment	☐	Sinus Trouble
☐	Angina pectoris	☐	Blood disease
☐	Cerebral palsy	☐	Drug addiction
☐	Joint replacement	☐	Nervous disorder

Please list any serious medical condition(s) that you have ever had :

_____

_____

_____

Are you allergic to any of the following?

Yes/No		Yes/No	
☐	Aspirin	☐	Erythromycin
☐	Penicillin	☐	Codeine
☐	Jewelry / Metals	☐	Tetracycline
☐	Dental anesthetics	☐	Latex
☐	Anesthetic (Novocain, ETC))	☐	Sulfa Drugs
☐	Other		

Please list any other drugs / Materials that you are allergic to :

_____

_____

_____

Dental history

Why have you come to the dentist today? _____

_____

_____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is : ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Are your teeth sensitive to ☐ Heat ☐ Cold

anything else? _____

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

Signature: _____ Date: _____

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(Year 1) Initials:_____ Date:_____

(Year 2) Initials:_____ Date:_____

(Year 3) Initials:_____ Date:_____

Year 2: Changes in health _____

Date: _____ Signature_____

Year 3: Changes in health _____

Date: _____ Signature_____

Health questionnaire must be updated each year