MEDICAL HISTORY Today's Date_____

Name _____Date of Birth_____
Address_____
Home # _____ Cell #_____ SSN_____
Employer_____Occupation_____Work #_____
E-Mail _____May we email and/or text you?_____ Yes _____No
Physician's Name/Address/Number_____

Date of last dental visit _____Previous dentist's name/town _____
Previous teeth cleaning frequency (circle): 3 months 4 months 6 months 12 months
How often do you brush per day? _____ How often do you floss?_____
Do you use (circle): mouthrinse Waterpik floss interdental brush battery toothbrush rubber tip other

Do you currently have (circle):

bleeding/sore gums	burning tongue/lips	frequent cold sores
cheek/lip biting	difficulty opening/closing jaw	clicking/popping jaw
orthodontics (braces)	unpleasant taste/bad breath	swelling/lumps in mouth
loose teeth	teeth sensitive to hot	periodontal treatment
food catching between teeth	teeth sensitive to cold	night-guard or mouth-guard
clenching/grinding	teeth sensitive to sweets	injury to mouth or head
change in bite	teeth sensitive to biting	mouth breathing

If you could change your smile, what would you do?_____
_____

FOR CHILDREN: When necessary and appropriate, we will apply fluoride and sealants and take x-rays.
Indicate any of these procedures you do NOT want for your child _____
Is your child taking a fluoride supplement?_____Yes ___No

Please circle:

1. Have you been under the care of a medical doctor during the past 2 years? Yes No
   If yes, for what? _____
2. Are you taking any medications/prescription drugs or supplements? Yes No
   Indicate any regular medications or supplements by name, dosage, and frequency:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
3. Are you allergic to or had a reaction to:
   Local anesthetics_____Yes No
   Penicillin or other antibiotic_____Yes No
   Sulfa drugs_____Yes No
   Barbiturates, sedatives, sleeping medications_____Yes No
   Aspirin, Advil/Motrin, Tylenol or Aleve_____Yes No
   Iodine_____Yes No
   Codeine or other narcotic_____Yes No
   Latex_____Yes No
   Other (indicate)_____Yes No

OVER

4. Indicate which of the following you have had, or have at present:

Rheumatic fever or rheumatic heart disease	Congenital heart disease
Artificial or replacement valves/joints	Pacemaker
Allergies	Hives or skin rash
Sinus trouble	Bacterial endocarditis
Asthma	Ulcer/colitis
Fainting	Tuberculosis
Hepatitis or liver disease	Herpes/cold sores/fever blisters
Kidney trouble	HIV or AIDS
Persistent cough	STD
Autoimmune disease	Diabetes
Abnormal bleeding	High blood pressure
Thyroid disease	Glaucoma
Heart murmur	Contact lenses
Mitral valve prolapse	Stroke
Emphysema, COPD	Bruise easily
Arthritis	Hemophilia
Epilepsy/seizures	Blood transfusion
Radiation therapy/Chemotherapy	Heart attack
Acid reflux or GERD	Eating disorder
Cancer	Anemia
Arteriosclerosis	Neurological disorder

5. Do you have pain in chest upon exertion? _____ Yes No
6. Are you short of breath after mild exercise? _____ Yes No
7. Do your ankles swell? _____ Yes No
8. Do you have to urinate more than six times a day? _____ Yes No
9. Are you thirsty much of the time? _____ Yes No
10. Does your mouth frequently become dry? _____ Yes No
11. Do you have to take an antiobiotic prior to dental treatment? _____ Yes No
12. Do you use any tobacco products? If so, type and amount_____ Yes No
13. Are you taking any of the following?

antibiotics or sulfa drugs	anticoagulant (blood thinners)	anti-anxiety drug
high blood pressure drug	cortisone (steroids)	antihistamine
aspirin	insulin or drug for diabetes	digitalis
nitroglycerin	antidepressant	

The following questions are related to sleep apnea:

14. Are you a loud and/or regular snorer?_____ Yes No
15. Do you gasp or stop breathing during sleep?_____ Yes No
16. Do you awake frequently during the night?_____Yes No
17. Do you feel tired or worn out during the day?_____Yes No
18. Do you wake up with a dry mouth or a sore throat?_____ Yes No

WOMEN: Are you pregnant? ___ Yes ___ No Are you nursing? ____Yes ___No
Are you taking birth control pills? ___ Yes ___No Hormone supplements? ____Yes ___No

_____ _____ _____ _____
Patient Signature Date Dentist Signature Date