Medical and Dental History

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dental studio

Patient Information

* First Name _____ Middle Initial _____ Last Name _____

General Health History

* How would you rate your general health? _____

* What do you consider to be your most important health issues?

_____

* Your Primary Care Physician's Name, Address, & Phone Number

_____

_____

* What is the date (or approximate date) of your last medical exam? _____

* Have you ever had complications following dental treatment? Please explain:

_____

* Do you have any dental phobias? Please explain:

_____

* Have you had any negative dental experiences? Please explain:

_____

Heart Health

* Have you ever had or have been treated for any of the following: congestive heart failure; congenital heart malformation; valve problems / murmur; chest pain / angina; heart attack / myocardial infarct; cardiac arrhythmia; pacemaker / defibrillator / VAD? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Vascular Health

* Have you ever had or have been treated for any of the following: high / low blood pressure; fainting / dizzy spells; central venous catheter / PICC; stroke; TIA? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Bleeding Disorders

* Have you ever had or have been treated for any of the following: hemophilia; anticoagulants; bruise easily; low /high platelets; anemia; transfusions; sickle cell disease? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Lung Health

* Have you ever had or have been treated for any of the following: asthma; bronchitis; emphysema; pulmonary fibrosis / scarring; chronic cough; shortness of breath; pneumonia; tuberculosis?
yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Liver Health

* Have you ever had or have been treated for any of the following: Hepatitis (A,B,C, autoimmune); jaundice; cirrhosis; alcoholism? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Digestive Tract

* Have you ever had or have been treated for any of the following: diet (special / restricted); ulcers / GI bleeding; gastric reflux / heartburn; colitis; crohns; IBS; constipation / diarrhea; hemorrhoids; esophagus disease? yes ☐ no ☐

If you answered yes, please specify which condition you have / had and provide any other details:

Kidney Health

* Have you ever had or have been treated for any of the following: dialysis; acute or chronic renal failure; polycystic? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Hormones

* Have you ever had or have been treated for any of the following: thyroid problems; diabetes / pancreas disease; pituitary / adrenal; gender hormone issues? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Muscles / Skeletal Health

* Have you ever had or have been treated for any of the following: osteoporosis; artificial joints (hip, knee, etc.); multiple sclerosis; myasthenia gravis; muscular dystrophy; trauma; swollen ankles?
yes ☐ no ☐

If you answered yes, please specify which condition you have / had and provide any other details:

Immunologic

* Have you ever had or have been treated for any of the following: lupus; other autoimmune disease; immunosuppressive therapy; use of prednisone or similar? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Psychiatric Health

* Have you ever had or have been treated for any of the following: psychiatric / psychologic care; nervous / anxious feelings; depression; developmental delay / autism; behavior issues; learning disability; alzheimer's / dementia? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Neurological Health

* Have you ever had or have been treated for any of the following: seizures / epilepsy; parkinson's; cerebral palsy? yes ☐ no ☐

If you answered yes, please specify which condition you have / had and provide any other details:

Head / Sinus Health

* Have you ever had or have been treated for any of the following: sinus trouble / hay fever; migraine headaches; cold sores / fever blisters; vision / hearing impairment? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Infectious Disease

* Are you HIV Positive? Have you ever had or been treated for a sexually transmitted disease? Have you ever had or been treated for any other infectious disease? yes ☐ no ☐

If you answered yes, please specify which condition(s) you have / had and provide any other details:

Cancer

* Have you ever had cancer? If yes, what type of cancer? Was your cancer treated with surgery, chemotherapy, radiation, or a combination of therapies? yes ☐ no ☐

If you answered yes, please specify what type of cancer you have / had and provide additional details:

Habits

* Do you have any of the following habits: soft drink consumption; snuff; drug abuse (street); cigarettes; alcohol; cigars; drug abuse (prescription)? yes ☐ no ☐

  If you answered yes, please specify which habit(s) you have / had and provide any other details:

* Do you use medical or recreational marijuana? yes ☐ no ☐
  If yes, what delivery method. Smoke ☐ Vapor ☐ Edible ☐ Topical ☐

* On average, how many alcoholic beverages per week do you consume? _____

* On average, how many soft drinks per week do you consume? _____

* On average, how many cigarettes do you consume per day? _____

Other General Health Questions

* Have you been treated with oral or IV bisphosphonate medications (usually for osteoporosis or chemotherapy)? yes ☐ no ☐

  If yes, please list and describe in the section below:

* Please list all medications you are currently taking including over-the-counter and herbal products. Also include dosage, frequency, and the reason you are taking the medication.

* Please list any allergies and/or bad reactions you have had. Include what you reacted to, what happened to you, and how severe it was:

* Please list all operations and / or hospitalizations you have had and approximate dates:

* Would you like to speak to the dentist privately about any health issues? yes ☐ no ☐

Women Only

* Do you use birth control pills or injection? yes ☐ no ☐ * Are you pregnant? yes ☐ no ☐

* If you are pregnant, what is your estimated date of delivery? _____

* If you are pregnant, who is your MD or midwife? _____

Acknowledgment

* To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail. I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

Relationship of person completing this form to the patient _____

Signature

Date