



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? yes no

* Do you have any dental phobias? yes no

* Have you had any negative dental experiences? yes no

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

If any of the previous questions are marked yes, please explain:

Lung / Head / Sinus 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

* 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:

Cancer / Bisphosphonate Use / Muscles / Skeletal Health

* 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

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

* 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:

Digestive Tract / Immunologic

- * 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
- * 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:

Liver / Kidney Health / Hormone Use

- * Have you ever had or have been treated for any of the following: Hepatitis (A,B,C, autoimmune); jaundice; cirrhosis; alcoholism? yes no
- * Have you ever had or have been treated for any of the following: dialysis; acute or chronic renal failure; polycystic? yes no
- * 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:

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? _____

- * Are you interested in resources or information about quitting? yes no

Other General Health Questions

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

- * Do you use birth control pills or injection? yes no

- * Are you pregnant? yes no

- * Estimated date of delivery? _____

- * Who is your MD or midwife? _____

- * If you are interested in sedation dentistry and trying to get pregnant, please discuss with the dentist

Psychiatric / Neurological 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
- * 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:

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:

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 _____