MEDICAL AND DENTAL HISTORY (2024)

Patient Name: _____ DOB: _____ Sex: _____

Address: _____

Choose one:

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ More than one Race

☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Hispanic/Latino

MEDICAL HISTORY:

Are you under the care of a Physician? ☐ Yes ☐ No

If yes, for what reason? _____

Name of Physician: _____ Phone Number: _____

Physician's Address: _____

When was your last visit? _____

Are you presently taking any prescription medications? ☐ Yes ☐ No Please list:

_____

Are you presently taking any over the counter medications, vitamins or supplements? ☐ Yes ☐ No Please list:

_____

Have you taken antibiotics that were prescribed to someone else? ☐ Yes ☐ No Please list:

_____

Are you allergic (or have an adverse reaction, hives, rash, etc..) to any medication?

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Aspirin ☐ None

☐ Other medication : _____

Are you sensitive or allergic to latex? (I.e. Experienced Itching, rash or wheezing after using latex gloves or handling a balloon). ☐ Yes ☐ No If yes, please explain: _____

Have you had any unusual or unexplained reactions during a surgical procedure? ☐ Yes ☐ No If yes, please explain:

_____

Have you ever been told by a medical provider that you have the following (Yes or No)

☐ Heart Murmur
☐ Rheumatic Fever
☐ Rheumatic Heart Disease
☐ Atrial Fibrillation
☐ Congenital Heart Disease
☐ Mitral Valve Prolapse
☐ High Blood Pressure/Hypertension
☐ Chest Pain/Angina
☐ Stroke If yes, when? _____
☐ Heart Attack If yes, when? _____
☐ Emphysema/COPD
☐ Lung Disease
☐ Asthma
☐ Anorexia
☐ Bulima
☐ Other Conditions:
_____
_____
_____

☐ Arthritis/Rheumatism
☐ Tuberculosis
☐ Diabetes If yes, recent HbA1C?_____
☐ Epilepsy
☐ Convulsions/ Seizures
☐ Cancer If yes, what kind/where?_____
_____
☐ Kidney Problems
☐ Kidney Disease If yes, what stage? _____
☐ Herpes (HSV1, HSV2, Cold sores, Fever blisters)
☐ Chlamydia
☐ Syphilis
☐ Hepatitis A☐ B☐ C☐
☐ HPV
☐ Gonorrhea
☐ HIV/AIDS If yes, CD4? _____
ViralLoad?_____ANC?_____
☐ Osteoporosis
☐ Thyroid Disease Hypo ☐ Hyper ☐
☐ High Cholesterol

☐ Liver Disease
☐ Learning Disability
☐ Mental Health Conditions
☐ Anxiety
☐ Frequent Headaches
☐ Hemophilia
☐ Anemia
☐ Excessive Bleeding/Bruising
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Alcohol Dependence
☐ Chemical Dependency
☐ Ulcers If yes, what type? _____
☐ Glaucoma
☐ Acid Reflux/GERD
☐ Sleep Apnea

Have you ever received the following (Yes or No)

☐ Heart Surgery Date: _____
☐ Artificial Heart Valve
☐ Heart Pacemaker
☐ Cortisone Medicine
☐ Gallbladder Surgery

☐ Prosthetic Implants
☐ Artificial Joints If yes, what joint & when?_____
☐ Bisphosphonate Use (Alendronate/Fosamax, Risedronate/Actonel, Ibandronate/Boniva, etc.)
☐ Dialysis If yes, what days? _____

☐ Removal of Spleen
☐ Radiation Therapy If yes, location?_____
☐ Chemotherapy
☐ Blood Transfusion

Have you had any serious illness, hospitalization, or accident? If yes, explain:
_____

Do you currently smoke or use the following tobacco products?
☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew/Dip Tobacco ☐ Vape/E-cigarettes ☐ None

Have you used Tobacco products in the past? ☐ Yes ☐ No; If yes, when did you quit? _____

Any recreational drug use? ☐Pain Medication (not prescribed by a physician. ex: Vicodin, Norco, Heroin, Fentanyl) ☐Marijuana ☐Cocaine

☐*Methamphetamine* ☐*Stimulants* *(not prescribed by a physician. ex: Adderall, Ritalin, etc..)* ☐*Hallucinogens* *(ex: LSD, PCP, etc..)*

☐Sedatives (not prescribed by a physician. ex: Valium, Klonapin, Xanax, Halcion)

Do you drink beer, wine or alcohol? ☐ Yes ☐ No If yes, how often? _____

WOMEN: Are you pregnant? ☐ Yes ☐ No Do you anticipate becoming pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Do you take birth control medications? ☐ Yes ☐ No

DENTAL HISTORY:

When was the last time you saw a dentist: _____

Do you have any dental problems now? ☐ Yes ☐ No If yes, please describe:

_____

Does dental treatment make you nervous? ☐ Yes ☐ No

Is there anything about receiving dental care that concerns you? ☐ Yes ☐ No If yes, explain:

_____

Any sensitivity to ☐ Cold ☐ Hot ☐ Sweets ☐ Chewing

Do you have any of the following: ☐ Bleeding Gums ☐ Bad Breath ☐ Grind teeth at night ☐ Clicking Jaw

How often do you brush your teeth? _____ How often do you floss? _____

What other aids do you use? (Electric toothbrush, toothpick, etc.) _____

Comments: