## Medical and Dental History

Patient Name: _____ Date of Birth: _____
Address:_____Postal:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Preferred Method of Contact (Circle one): Home Work Cell Email
Preferred Confirmation Method (Circle one) : Text Email Phone call
**Emergency Contact (name & phone number)**: _____

*Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you receive. We thank you for your cooperation in answering the following questions.*

Are you currently under a physician's care (family doctor /specialist) □ YES □ NO
**Doctor's name and phone number**: _____

Are you taking any medication, vitamins or herbal supplements? □ YES □ NO
If yes, please list: _____

_____

**Pharmacy name and location**: _____

Have you ever been hospitalized or had a major operation? □ YES □ NO
If yes, please explain: _____

Have you ever had a serious head, neck or jaw injury? □ YES □ NO
If yes, please explain: _____

Are you on a special diet? □ YES □ NO

Do you smoke, chew tobacco or use controlled substances? □ YES □ NO

Women: Are you pregnant? □ YES □ NO Due Date: _____

Taking Contraceptives? □ YES □ NO

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Sulfa Drugs □ Codeine □ Local Anesthetic

□ Acrylic □ Metal □ Latex

□ Other? Please explain: _____

Do you have, or have you ever had, any of the following? Check all that apply

□ AIDS/HIV Positive
□ Allergies/Anaphylaxis
□ Dementia/Alzheimer's disease
□ Anemia
□ Arthritis/Gout
□ Artificial Joint
□ Asthma/Breathing problems
□ Blood Transfusion
□ Cancer
□ Chemotherapy
□ Chest Pains
□ Congenital Heart Disorder
□ Diabetes
□ Drug Addiction
□ Excessive Bleeding
□ Excessive Thirst
□ Frequent Cough
□ Frequent Headaches
□ Glaucoma
□ Hay Fever
□ Heart Attack/Failure/Angina
□ Heart Murmur
□ Hemophilia
□ Hepatitis A, B or C
□ High Cholesterol
□ High/Low Blood Pressure
□ Hypo/Hyperglycemia
□ Irregular Heartbeat
□ Kidney Problems
□ Liver Disease
□ Lung Disease
□ Mitral Valve Prolapse
□ Osteoporosis
□ Psychiatric Care
□ Radiation Treatments
□ Recent Weight Loss
□ Rheumatic Fever
□ Scarlet Fever
□ Sickle Cell Disease
□ Sinus Trouble
□ Stomach/Intestinal/Ulcer
□ Stroke
□ Thyroid disease
□ Tonsillitis
□ Tumors or Growth
□ Fainting spells/Dizziness

Have you ever had any conditions or diseases not listed above? _____

When/where was your last dental visit? _____
When did you last have x-rays? _____
How often do you brush your teeth? _____How often do you floss your teeth? _____
Are you nervous during dental appointments? □Yes □No
Are you currently experiencing any dental problems/concerns? □Yes □No
If yes, please explain: _____
Are your teeth sensitive to hot/cold? □Yes □No If yes, where?: _____
Are your teeth sensitive to biting/chewing/sweets? □Yes □No If yes, where?:_____
Have you ever had (check all that apply): □Braces □Oral surgery □Dental implants □Gum surgery
Have you ever, or do you currently (check all that apply): □Grind/clench your teeth □Chew gum □Bite your cheeks/nails □Breath through your mouth □Suck finger/thumb □Eat candy □Drink pop

**How did you hear about us?** _____

To the best of my knowledge the above information has been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any medical changes.

_____ _____
Signature of Patient/ Parent/ Guardian Date

_____
Signature of Dental Provider