Medical History

Last Name: ____________________ First Name: ____________________ Birthdate: ____________________

Emergency Contact ______________________________ Phone _____________ Relationship _____________

Physician's Name: ______________________________ Phone _____________

List all medications you are currently taking:

____ ____

____ ____

____ ____

____ ____

____ ____

Are you taking or have you ever taken bisphosphonates? ☐Y ☐N
(Fosamax, Boniva, Actonel, Zomedia)

Are you allergic to any of the following?

	Y	N		Y	N
Local Anesthetic	☐	☐	Latex	☐	☐
Aspirin	☐	☐	Penicillin	☐	☐
Codeine	☐	☐	Sulfa	☐	☐
Iodine	☐	☐	Metals (please specify): _______________	☐	☐

Please indicate if you have or have had any of the following:

	Y	N		Y	N		Y	N
AIDS/HIV Positive	☐	☐	Heart Conditions:			Kidney Disease	☐	☐
Asthma	☐	☐	Artificial Heart Valve	☐	☐	Liver Disease	☐	☐
Bleeding Problems	☐	☐	Congenital Heart Defect	☐	☐	Osteoporosis	☐	☐
Cancer	☐	☐	Heart Attack	☐	☐	Rheumatic Fever	☐	☐
Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Emphysema	☐	☐	Pacemaker	☐	☐	Tobacco Use	☐	☐
Epilepsy/Seizures	☐	☐	Joint Replacement	☐	☐	Tuberculosis (TB)	☐	☐
Fainting/Dizzy Spells	☐	☐	Date: _____________			Venereal Disease	☐	☐
HPV	☐	☐						

Is there anything else we should know about your medical history? ☐Y ☐N
Please specify: ____

Have you been hospitalized in the past 3 years? ☐Y ☐N
Please explain: ____

For Women Only:

Are you taking birth control pills? ☐Y ☐N

Are you nursing/breastfeeding? ☐Y ☐N

Are you or could you be pregnant? ☐Y ☐N
Expected delivery date: _______________

Dental History

Reason for today's visit: ______________________________

Date of last cleaning and exam: ______________________________

Date of last x-rays: __________

Have you ever had a popping or clicking near your ear when you chew? ☐Y ☐N

Are you prone to frequent headaches? ☐Y ☐N

Do you grind or clench your teeth? ☐Y ☐N

If yes, do you wear a nightguard? ☐Y ☐N

Do you have sores, blisters, or swelling on your gums, lips, or cheeks? ☐Y ☐N

Have you or a family member every been treated for periodontal disease? ☐Y ☐N

Are your teeth sensitive to hot, cold, or pressure? ☐Y ☐N

Is there anything you want to change about your smile?

____

I certify that I have read and understood the above questions. I acknowledge that my questions have been answered accurately and completely. I will not hold my dentist or any members of his/her staff responsible for any errors or omissions I have made in completion of this form.

______________________________ Date:

Signature of Patient/Parent or Guardian