New Dental/ medical history 2020(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your 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 will receive. Thank you for answering the following questions.

Dental Information

Do you have, or have you had, any of the following?

Gums bleed when you brush or floss?	Yes No	Are your teeth sensitive?	Yes No
Is your mouth dry?	Yes No	Have you had any periodontal treatments?	Yes No
Have you ever had braces?	Yes No	Anxiety with dental treatment?	Yes No
Is your home water supply fluoridated?	Yes No	Experiencing dental pain or discomfort?	Yes No
Do you have earaches or neck pains?	Yes No	Clicking or discomfort in the jaw?	Yes No
Do you brux or grind your teeth?	Yes No	Sores or ulcers in your mouth?	Yes No
Problems with prior dental treatments	Yes No	Do you wear dentures or partials?	Yes No
Serious injury to head or mouth?	Yes No		

Date of your last dental exam:

Date of last dental xrays:

What is the reason for your dental visit today?

Medical information

Who is your primary care doctor? (If any)		Comment	
Have you ever had joint replacement? Where and by who?	Yes No	If yes	
Heart surgeries? Where and by who?	Yes No	If yes	
What premedication do you require from previous question?	Yes No	If yes	
Are you taking any controlled substances?	Yes No	If yes	
Are you taking any medications? Please list all	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Do you use any type of Tobacco, Marijuana, or vape?	Yes No		

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A, B or C	Yes No	Anaphylaxis	Yes No
Drug Addiction	Yes No	Renal Dialysis	Yes No	Anemia	Yes No	Easily Winded, Breathing problems	Yes No
Rheumatic Fever	Yes No	Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No
Arthritis/Gout/Rheumatism	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Artificial Heart Valve	Yes No
Excessive Bleeding/Bruise Easily	Yes No	Shingles	Yes No	Artificial Joint	Yes No	Excessive Thirst	Yes No
Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No	Fainting Spells/Dizziness	Yes No
Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Frequent Cough	Yes No	Kidney Disease	Yes No
Spina Bifida	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No	Liver Disease	Yes No
Stroke	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer/Tumors	Yes No
Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No
Seasonal Allergies	Yes No	Mitral Valve Prolapse	Yes No	Chest Pains	Yes No	Heart Attack/Failure	Yes No
Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No
Congenital Heart Disorder	Yes No	Pacemaker	Yes No	Parathyroid or Thyroid Disease	Yes No	Heart Trouble/Disease	Yes No
Psychiatric Care	Yes No	GE Reflux/ Persistent Heartburn	Yes No	Lupus	Yes No	Eating Disorder	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____