

MEDICAL AND DENTAL HISTORY (2023)

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? Please list: _____

Are you presently taking any over the counter medications, vitamins or supplements? 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). If yes, please explain: _____

Have you had any unusual or unexplained reactions during a surgical procedure? If yes, please explain: _____

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

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Rheumatic Heart Disease	<input type="checkbox"/> Diabetes If yes, recent HbA1C? _____	<input type="checkbox"/> Mental Health Conditions
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Convulsions/ Seizures	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Cancer If yes, what kind/where? _____	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> High Blood Pressure/Hypertension	_____	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chest Pain/Angina	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Excessive Bleeding/Bruising
<input type="checkbox"/> Stroke	<input type="checkbox"/> Herpes (HSV1, HSV2, Cold sores, Fever blisters)	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Alcohol Dependence
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Hepatitis A__ B__ C__	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Asthma	<input type="checkbox"/> HPV	<input type="checkbox"/> Ulcers If yes, what Type _____
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Bulimia	<input type="checkbox"/> HIV/AIDS If yes, CD4? _____	<input type="checkbox"/> Acid Reflux/GERD
<input type="checkbox"/> Other	<input type="checkbox"/> ViralLoad? _____ ANC? _____	
Conditions: _____	<input type="checkbox"/> Osteoporosis	
_____	<input type="checkbox"/> Thyroid disease Hypo ___ Hyper ___	<input type="checkbox"/> Sleep Apnea
_____	<input type="checkbox"/> High Cholesterol	

Have you ever received the following (Yes or No)

<input type="checkbox"/> Heart Surgery Date: _____	<input type="checkbox"/> Prosthetic Implants	<input type="checkbox"/> Removal of Spleen
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Artificial Joints If yes, what joint & when? _____	<input type="checkbox"/> Radiation Therapy If yes, location? _____
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Bisphosphonate Use (Alendronate/Fosamax, Risedronate/Actonel, Ibandronate/Boniva, etc.)	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Gallbladder Surgery		

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

Do you currently use any of these 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, Klonopin, Xanax, Halcion)

How often do you have a drink of beer, wine or alcohol? daily 2-3 times weekly monthly never

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:

Is there anything about receiving dental care concern 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: _____