Medical History Update

Patient Name: _____ Date of Birth: _____

Phone Number: _____ SSN #: _____

Address: _____

Preferred Pharmacy and Phone Number: _____

Emergency contact and Phone #: _____

Please take a moment to let us know about your medical history so we may serve you more efficiently and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ○ YES ○ NO

Within the past year, were there any changes in your general health? ○ YES ○ NO

What is the date (or approximate date) of your last medical exam?

○ YES ○ NO Have you ever had complications following dental treatment?

○ YES ○ NO Are you currently under the care of a physician due to a specific condition?

○ YES ○ NO Have you been hospitalized within the last 5 years due to a surgery or illness?

○ YES ○ NO Are you currently taking any prescription or non-prescription medications?

○ YES ○ NO Do you use tobacco (smoking or chewing)?

○ YES ○ NO Do you require the use of corrective lenses (contacts or glasses)?

Please indicate which of the following conditions you currently have or have had. We prefer to keep a complete medical history on file for our patients so the more information we have, the better it is for us to care for you.

☐ *Pre-Med Amoxicillin	☐ Bisphosphonates	☐ Immune Suppression
☐ *Pre-Med Clindamycin	☐ Bleeding Disorder	☐ Joint Replacement
☐ *Pre-Med Other	☐ Blood Pressure-High	☐ Kidney Disease
☐ ADD/ADHD	☐ Blood Thinner	☐ Liver Disease
☐ Anxiety	☐ Cancer	☐ Lung Disease
☐ Autism Spectrum Disorder	☐ Chemo/Radiation	☐ Lyme Disease
☐ Depression	☐ Chicken Pox/Shingles	☐ Migraine Headaches
☐ Eating Disorder	☐ COVID-19	☐ Neurologic Disorder
☐ Mental Health Condition - Other	☐ COVID-19 Vaccine	☐ Osteoporosis
☐ Tourette's/Tics	☐ Diabetes Type I / II	☐ Radiation (Head/Neck)
☐ Accessibility Needs	☐ Drug / Alcohol Dependence	☐ Recreational Drugs
☐ Acid Reflux (GERD)	☐ Dry Mouth	☐ Seasonal Allergies
☐ Allergy Food	☐ Glaucoma	☐ Seizure Disorder
☐ Allergy Metals	☐ Head Injury	☐ Sleep Apnea /CPAP
☐ Allergy Other	☐ Hearing Aid / Loss	☐ Stomach Problems
☐ Allergy Other Meds	☐ Heart Attack	☐ Stroke
☐ Allergy Penicillin	☐ Heart Condition	☐ Surgery
☐ Alzheimer's/Dementia	☐ Heart Surgery	☐ Thyroid Disease
☐ Arthritis	☐ Heart Valve Replaced	☐ Tobacco Use
☐ Asthma	☐ Hepatitis A, B or C	☐ Trauma / Accident
☐ Back or Neck Problems	☐ HIV +	☐ Vape Use

Comments on conditions or alerts listed above:

Allergies not listed:

Do you take antibiotic premedication for your dental visits? If yes, please explain below:

FEMALES ONLY:

Are you currently pregnant?	○ YES	○ NO
Have you had complications with pregnancy?	○ YES	○ NO
Are you breastfeeding?	○ YES	○ NO
Are you taking Birth control Pills?	○ YES	○ NO

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment below:

Please list all medications you are taking below (or bring in a list with you to your appointment):

Please write below anything else we may need to know to give you our best possible dental care. Thank you for taking the time to fill out this form in its entirety!

☐ *By checking this box, I acknowledge that I have reviewed ALL questions / alerts on the questionnaire and responded accordingly. There are no other medical conditions/ allergies that have not been listed. I am aware that I must notify the practice of any changes in the future.

Signature and Date:

_____

Additional Information

What is the most important thing to you about your visit today?

_____

How can we best help you with your future smile and dental health?

_____

On a scale of 1 to 10 (1: lowest, 10: highest), how important is your dental health to you? _____

On a scale of 1 to 10 (1: lowest, 10: highest), how would you rate your current dental health? _____

Is there any other information regarding your dental health or smile you would like us to know?

_____

_____

_____

If you could change your smile or dental health, what would you do? Check all that apply:

- ☐ You like your smile the way it is
- ☐ Make it brighter
- ☐ Close the spaces
- ☐ Replace missing teeth
- ☐ Replace black metal fillings with tooth-colored fillings
- ☐ Make it straighter
- ☐ Repair chipped teeth

Check all that apply:

- ☐ Bleeding, swollen, or irritated gums
- ☐ Treated for gum disease or told you have bone loss around your teeth
- ☐ Anyone in your family with a history of being treated for gum disease
- ☐ Bad breath or bad taste in mouth
- ☐ Have ever whitened or bleached your teeth
- ☐ Had trouble getting numb
- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces or orthodontic treatment
- ☐ Loose, tipped, or shifting teeth
- ☐ Popping or clicking jaw
- ☐ Pain or tenderness in jaw/ear/face
- ☐ Difficulty opening or closing jaw
- ☐ Clenching or grinding teeth
- ☐ Wear/have worn a nightguard
- ☐ Frequent headaches, earaches, or neck pain
- ☐ Any teeth sensitivity to hot, cold, or sweets
- ☐ Teeth that hurt if you bite on them just the right way
- ☐ Tooth pain or discomfort when chewing
- ☐ Teeth/fillings breaking
- ☐ You avoid brushing any part of your mouth
- ☐ Food gets trapped between your teeth
- ☐ Experienced gum recession
- ☐ You snore or wake up frequently during the night
- ☐ Diagnosed with sleep apnea
- ☐ Experienced dry mouth
- ☐ Experience a burning sensation in your mouth
- ☐ History of many ear infections / sinus infections in your past with antibiotics