

# Medical Health History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? \_\_\_\_\_

Have you ever had a serious head or neck injury? \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_

Do you use controlled substances? \_\_\_\_\_

**Please check the box of any conditions you have or have had.**

## Allergies None

- |  |                                       |   |                                      |
|--|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Acetaminophen         | <input type="checkbox"/> Codeine      | <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Aspirin               | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals           | _____                                |
| <input type="checkbox"/> Barbituates/sedatives | <input type="checkbox"/> Ibuprofen    | <input type="checkbox"/> Penicillin       |                                      |
| <input type="checkbox"/> Cephalosporins        | <input type="checkbox"/> Latex        | <input type="checkbox"/> Sulfa            |                                      |

## Health Issues

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Pacemaker        | <input type="checkbox"/> Radiation Treatment      |
| <input type="checkbox"/> Anemia/Sickle Cell     | <input type="checkbox"/> Congenital Heart Defect   | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Respiratory Disease/COPD |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Congestive Heart Failure  | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Rheumatic Fever          |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Sinus Problems           |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Dizziness/Fainting        | <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Eating Disorder           | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Thyroid                  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Epilepsy/Seizures         | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Breathing/Sleep Issues | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Tumors                   |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Mental Disorder        | <input type="checkbox"/> Ulcers/GERD              |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Organ Transplant       | <input type="checkbox"/> Other                    |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Osteoporosis           |   |

## Medications

*List all medications, supplements, and vitamins*


Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# Dental History Form

Patient Name: \_\_\_\_\_ Age \_\_\_\_\_

Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ I see my Dentist (circle): 3 M 6 M 12 M Not Routinely

What is your immediate concern? \_\_\_\_\_

On a scale of 1-10 (10 greatest), how important is your dental health? 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 (10 greatest), how would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 (10 greatest), how fearful are you of dental treatment? 1 2 3 4 5 6 7 8 9 10

Personal History	Yes	No
1. Have you had an unfavorable dental experience?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had complications from past dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had trouble getting numb or had any reactions to local anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have, or have you had, any teeth removed or teeth that never developed?	<input type="checkbox"/>	<input type="checkbox"/>
5. Did you ever have orthodontic treatment, braces, or your bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>

Gum/Bone History- Periodontal	Yes	No
6. Do your gums bleed or do they hurt during brushing/flossing?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been told you have gum disease or are losing bone around your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever noticed an unpleasant taste/smell in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does anyone in your family have a history of periodontal/gum disease?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you experienced gum recession (teeth look longer)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had any teeth becomes loose on their own?	<input type="checkbox"/>	<input type="checkbox"/>

Tooth Structure History- Cavities	Yes	No
12. Have you had any cavities within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the amount of saliva in your mouth seem to little or do you have trouble eating/swallowing food?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you feel or notice any holes on the tops of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
15. Are your teeth sensitive to hot, cold, or sweets or do you avoid brushing any area?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have grooves or notches on your teeth near the gumline?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever broken, chipped, or cracked any teeth or had a toothache?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you get food caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

Occlusion History- Bite, Jaw & TMJ	Yes	No
19. Do you have problems with your jaw joint? (pain, popping, cracking, locking)	<input type="checkbox"/>	<input type="checkbox"/>
20. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	<input type="checkbox"/>	<input type="checkbox"/>
21. Are your teeth becoming more crooked, crowded, or overlapped?	<input type="checkbox"/>	<input type="checkbox"/>
22. Are your teeth developing spaces or becoming loose?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you clench your teeth during the day or night or wake with a headache?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you wear, or have you ever worn, a bite appliance?	<input type="checkbox"/>	<input type="checkbox"/>

Cosmetic History- Smile	Yes	No
25. Is there anything about the appearance of your teeth that you would like to change?	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you ever whitened/bleached your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you been disappointed with the appearance of previous dental work?	<input type="checkbox"/>	<input type="checkbox"/>