

# 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"/> |