Patient History1

Patient Name: Birth Date: Date Created:

General Dentist - Name	
Family Physician - Name, City or Phone	
Specialist Physician - Name, City or Phone	
In Case of Emergency - Name, Phone	
Preferred Pharmacy - Name, Street, City	

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take supplements, herbals, or vitamins?	◯ Yes ◯ No	If yes	
Do you take blood thinners (Plavix, Coumadin, Aggrenox, Eliquis, fish oil, 325 mg aspirin)?	◯ Yes ◯ No		
Have you taken bisphosphonates (Fosamax, Boniva, Actonel)? IV, Injection, Oral? For how long?	◯ Yes ◯ No	If yes	
Do you use tobacco? If so, how much and for how long? If quit, give date.	◯ Yes ◯ No	If yes	

Are you allergic to or reacted adversely to any of the following?

☐ Latex	☐ Codeine	☐ Ibuprofen/NSAIDs/Aspirin
☐ Penicillin	☐ Sulfa	☐ Local Anesthetic
☐ Medical tape	☐ Other	☐ Other Antibiotics

Women:

☐ Pregnant	☐ Trying to get pregnant	☐ Nursing
☐ Taking oral contraceptives	☐ Menopause	

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

ADHD ◯ Yes ◯ No	Allergies ◯ Yes ◯ No	Alzheimer's/Dementia ◯ Yes ◯ No	Anemia ◯ Yes ◯ No
Arthritis ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Bariatric surgery ◯ Yes ◯ No	Blood disease ◯ Yes ◯ No
Blood pressure: high ◯ Yes ◯ No	Blood pressure: low ◯ Yes ◯ No	BPH ◯ Yes ◯ No	Bruise easily ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	COPD ◯ Yes ◯ No	Depression ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No	Drug/alcohol addiction ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	Epilepsy/seizures ◯ Yes ◯ No
Fainting/dizziness ◯ Yes ◯ No	GERD ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Gout ◯ Yes ◯ No
Headaches/migraines ◯ Yes ◯ No	Heart attack ◯ Yes ◯ No	Heart: artificial valve ◯ Yes ◯ No	Heart:congenital disorder ◯ Yes ◯ No
Heart: pacemaker ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No
High cholesterol ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Immunosuppression ◯ Yes ◯ No	Joint replacement ◯ Yes ◯ No
Kidney disease ◯ Yes ◯ No	Liver disease ◯ Yes ◯ No	Organ transplant ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Panic attack ◯ Yes ◯ No	Parkinson's ◯ Yes ◯ No	Psoriasis ◯ Yes ◯ No	Psychiatric care ◯ Yes ◯ No
Radiation to head/neck ◯ Yes ◯ No	Rheumatic fever ◯ Yes ◯ No	Rheumatoid arthritis ◯ Yes ◯ No	Sinus trouble ◯ Yes ◯ No
Sleep apnea ◯ Yes ◯ No	Stomach ulcers ◯ Yes ◯ No	Stroke/TIA ◯ Yes ◯ No	Thyroid disease ◯ Yes ◯ No
Tonsilitis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Weight loss recently ◯ Yes ◯ No	HIV/AIDS ◯ Yes ◯ No

Any serious illness or surgery not listed? ◯ Yes ◯ No If yes

Dental History

When was the last time you had your teeth cleaned?

How often do you have your teeth cleaned?

How often do you brush?

Do you use:

Electric or battery brush	◯ Yes	◯ No
Floss	◯ Yes	◯ No
Proxabrush or rubber tip	◯ Yes	◯ No
WaterPik	◯ Yes	◯ No
Rinse	◯ Yes	◯ No
Whitening products	◯ Yes	◯ No
Retainer	◯ Yes	◯ No
Bitesplint/night guard	◯ Yes	◯ No

Have you ever had:

Periodontics (gum treatment)	◯ Yes	◯ No
Orthodontics (braces)	◯ Yes	◯ No
Endodontics (root canal)	◯ Yes	◯ No
Dental implant	◯ Yes	◯ No
Bad dental experience	◯ Yes	◯ No
Injury to mouth or face	◯ Yes	◯ No
Cold sores/fever blisters	◯ Yes	◯ No
Canker sores	◯ Yes	◯ No

Dental History Continued...

Do you have:

Pain in mouth	◯ Yes	◯ No
Bleeding gums	◯ Yes	◯ No
Receeding gums	◯ Yes	◯ No
Sensitive teeth	◯ Yes	◯ No
Bad taste or odor	◯ Yes	◯ No
Difficulty chewing	◯ Yes	◯ No
Loose teeth	◯ Yes	◯ No
Dry mouth	◯ Yes	◯ No
TMD/jaw joint problems	◯ Yes	◯ No
Clenching/grinding	◯ Yes	◯ No

Are you interested in sedation for treatment? ◯ Yes ◯ No

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:_____