PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient name _____ Preferred name _____ Birth date_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check ALL that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina (chest pain)
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart valve surgery/replacement
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint
  Date of joint replacement_____
- ❑ Endocarditis
- ❑ Stroke
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Ulcer
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Glaucoma
- ❑ Anemia
- ❑ Hemophilia
- ❑ Any other blood disorder not previously mentioned
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hay fever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you consume alcohol? ❑ yes ❑ no

If yes, how many drinks/week?_____

Do you smoke or vape? ❑ yes ❑ no

If yes, how much?_____

Do you use chewing tobacco? ❑ yes ❑ no

If yes, how much?_____

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

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking or have you EVER taken any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids (prednisone, etc)
- ❑ Osteoporosis (bone density) medicine (oral or IV)
- ❑ Radiation treatment
- ❑ Chemotherapy treatment

_____

Women:

- ❑ Pregnant or trying to become pregnant
  Expected delivery date: _____
- ❑ Taking hormones
- ❑ Taking contraceptives

TURN OVER TO COMPLETE THE BACK PAGE

Name of physician _____

Names of any medical specialists seen_____

Any medical conditions not listed above_____

_____

Please list **ALL** medications, vitamins, or supplements you are currently taking. If you do not take anything, please check the box below.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

- ❑ I do **not** take **any** medications, vitamins, or supplements

Dental History

Reason for visit today: _____ Referred by: _____

Date of last dental cleaning: _____

How often do you brush? _____ How often do you floss?_____

Do you have dental pain or concerns? If so, describe: _____

_____

Please add anything else you would like us to know about:_____

_____

Signature of patient _____ Date _____

Signature of parent or guardian (if applicable) _____ Date_____

Relationship to patient _____