MODERN DENTISTRY
Comprehensive • Implant • Sedation

# *Medical History*

Chart #: _____

Name: _____ Date: _____/_____/20_____ Age: _____

1. Why are you here today? _____

❑ Yes ❑ No 2. Are you having pain or discomfort at this time? Where? _____
How Long? _____ What makes it worse? _____

❑ Yes ❑ No 3. Do you feel very nervous about having dental treatment? Why?_____
_____

❑ Yes ❑ No 4. Have you ever had a bad experience in the dental office? Please explain. _____
_____

❑ Yes ❑ No 5. Are you dissatisfied with the appearance of your teeth?

❑ Yes ❑ No 6. Have you been under the care of a medical doctor during the past two years?
Regular Physician's Name _____
Address _____ Phone _____

❑ Yes ❑ No 7. Are you currently taking any medications or drugs, including herbals?
If yes, please list ALL of them: _____
_____
_____

❑ Yes ❑ No 8. Have you been a patient in the hospital during the past two years?

❑ Yes ❑ No 9. Have you had surgery in the past two years? What kind? _____
Were there any complications? ❑ Yes ❑ No

❑ Yes ❑ No 10. Are you allergic to any of the following? Please check all that apply.

| | | | |
|---|---|---|---|
| ❑ Aspirin | ❑ Nitrous Oxide | ❑ Valium | ❑ Penicillin |
| ❑ Darvocet | ❑ Erythromycin | ❑ Latex | ❑ Sulfites |
| ❑ Codeine | ❑ Local Anesthetics | ❑ Tetracycline | ❑ Amoxicillin |
| ❑ Vicodin | ❑ Nembutal/Seconal (sleeping pills) | ❑ Other antibiotics: _____ | |

❑ Yes ❑ No 11. Are you aware of being allergic to ***any other*** medication, metal, or substance?
If yes, please list them: _____

❑ Yes ❑ No 12. Do you require pre-medication? ❑ I'm not sure

❑ Yes ❑ No 13. Please **check** any of the following conditions which you have had or currently have. Please review this list carefully since your health and optimal treatment outcome may depend on your responses.

| | | |
|---|---|---|
| ❑ Artificial heart valve | ❑ Congenital heart defect | ❑ Heart murmur |
| ❑ Rheumatic heart disease | ❑ Bacterial endocarditis | ❑ Mitral valve prolapse |
| ❑ Artificial joints (Date of placement: _____ / _____ / _____ ) | | |
| ❑ Heart surgery | ❑ Heart failure | ❑ Angina Pectoris |
| ❑ Heart Disease or Attack | ❑ Heart pacemaker | ❑ Stroke |
| ❑ Narrow Angle Glaucoma | ❑ Thyroid disease | ❑ Pain in jaw joints |
| ❑ Liver disease | ❑ Hepatitis (Type ____ ) | ❑ Abnormal bleeding |
| ❑ Hemophilia | ❑ Anemia | ❑ Bruise easily |
| ❑ High blood pressure (Controlled blood pressure: _____ / _____ ) | | |
| ❑ Fainting or dizzy spells | ❑ Frequent headaches | ❑ Epilepsy or Seizures |
| ❑ Emphysema | ❑ Persistent cough | ❑ Allergies or hives |
| ❑ Tuberculosis (TB) | ❑ Hay fever | ❑ Sinus trouble |
| ❑ Asthma (Inhaler? ❑ Yes ❑ No; Last episode: _____ / _____ / _____ ) | | |
| ❑ Kidney trouble ❑ Diabetes (Type ❑ I ❑ II; Last Reading: _____ ) | | |
| ❑ Cortisone therapy | ❑ Arthritis | ❑ Drug addiction |
| ❑ Chemotherapy | ❑ Radiation Therapy | ❑ Cancer |
| ❑ Difficulty swallowing | ❑ Severe gag reflex | ❑ Ulcers |
| ❑ HIV or AIDS | ❑ Prolonged infections | ❑ Psychiatric treatment |
| ❑ Other: _____ | | |

*Notes*

***Continued on the next page***

❑ Yes ❑ No 14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are very tired?

❑ Yes ❑ No 15. Do you snore? How do you know? _____

❑ Yes ❑ No 16. Do you smoke or use smokeless tobacco?
If yes, how many packs do you smoke per day? _____
How many years have you smoked? _____

❑ Yes ❑ No 17. Do you drink soda/pop/sweetened carbonated beverages?
If yes, how may cans or servings per day? _____

18. Do you drink sweetened beverages such as coffee, tea, fruit juices (Snapple,
❑ Yes ❑ No etc.), or sports drinks (Gatorade, etc.)
If yes, how may cups or servings per day? _____

❑ Yes ❑ No 19. Do you eat candy/donuts/sugary foods?
❑ As part of or near my meals ❑ As a snack

20. Have you ever had ❑ Braces ❑ Gum Disease ❑ Periodontal Surgery
❑ Dental Implants ❑ Jaw Surgery ❑ Removal of Wisdom Teeth
Were there any complications? _____

❑ Yes ❑ No 21. Do you wake up with soreness/stiffness/pain in your face or upper neck?

❑ Yes ❑ No 22. Do you wake up with headaches?

❑ Yes ❑ No 23. Do you have a stressful day or job?

❑ Yes ❑ No 24. Do you chew gum? ❑ < 1hour/day ❑ > 1 hour/day

❑ Yes ❑ No 25. Have you had teeth, fillings, or crowns fall out, break, or chip in your mouth?

❑ Yes ❑ No 26. Does you jaw click or hurt when you chew?

❑ Yes ❑ No 27. Do you have fluoride in your water? ❑ I'm not sure

24. When was your last dental exam? ____/____/____ X-rays? ____/____/____

25. When was your last dental cleaning? ____/____/____

26. Times a day you brush? _____ Times a week you floss? _____

27. When do you brush your teeth? ❑ Morning ❑ Evening

28. When do you floss your teeth? ❑ Morning ❑ Evening

29. Do you have bad breath? ❑ Morning ❑ Noon ❑ Evening ❑ Bedtime

❑ Yes ❑ No 30. Do you use an electric tooth brush?

❑ Yes ❑ No 31. Do you use a tongue scraper?

**FOR WOMEN ONLY:**

Are you pregnant? ❑ Yes ❑ No If yes, what month? _____

Are you taking birth control pills? ❑ Yes ❑ No

*Notes*

_____

Medical Consult Needed:

❑ Blood test
❑ Blood thinner
❑ High BP
❑ High blood sugar
❑ SBE Prophylaxis
❑ Sedation
❑ Suspicious lesion
❑ Tonsils
❑ Other: _____

**To the best of my knowledge, all of the preceding answers are true and correct. I understand that this information will be held in confidence and will be used only to improve communication and treatment selection between my doctor and me. If I have any changes, I will be sure to update my medical history at the next appointment.**

**I hereby authorize the doctor to take any diagnostic records deemed necessary to make a thorough diagnosis of my dental needs and to perform any and all forms of treatment and therapy agreed upon by me.**

_____ _____/_____/20_____
Patient's signature Date

_____ _____/_____/20_____
Signature of parent or legal guardian (please circle one) Date

Reviewed by Doctor _____ _____/_____/20_____