Please Update Medical and Dental History

Patient Name: _____ D.O.B. _____ Today's Date: _____

Physician: _____ Phone: _____

Date of Last visit: _____ Reason: _____

Are you receiving medical care now? [ ] yes [ ] no. If yes, please explain: _____

_____

Medications:

Are you taking any medication(s) now? This includes prescription, over-the-counter medications, vitamins, and herbal remedies. [ ] yes [ ] no If yes, please specify: _____

What is the purpose of these medications? _____

Do you have any drug allergies or sensitivities? [ ] yes [ ] no. If yes, please specify: _____

_____

Have you ever taken bone density drugs? [ ] yes [ ] no

Do you have a latex allergy? [ ] yes [ ] no

Do you have any metal or jewelry allergy? [ ] yes [ ] no

Do you have any heart problems? [ ] yes [ ] no. If yes, please specify: _____

_____

Do you have any prosthetic joints- i.e. hip, knee? [ ] yes [ ] no. Date of replacements: _____

Tobacco history: Do you currently use tobacco? [ ] yes [ ] no. Have you used tobacco in the past? [ ] yes [ ] no.

If yes, when? _____ Are you interested in getting help to quit tobacco use? _____

Health History: Please check if you have or had:

[ ] high blood pressure	[ ] convulsions	[ ] rheumatic fever	[ ] venereal disease
[ ] low blood pressure	[ ] stroke	[ ] hepatitis A, B, C	[ ] ulcer
[ ] anemia	[ ] arthritis	[ ] tuberculosis	[ ] mononucleosis
[ ] excessive bleeding	[ ] rheumatoid arthritis	[ ] thyroid problems	[ ] bladder problems
[ ] asthma	[ ] diabetes	[ ] tonsillitis	[ ] measles
[ ] nervous problems	[ ] cerebral palsy	[ ] cancer	[ ] mumps
[ ] psychiatric care	[ ] malignancies	[ ] radiation treatment	[ ] chicken pox
[ ] hearing problem	[ ] chemotherapy	[ ] hay fever	[ ] HIV or AIDS
[ ] epilepsy	[ ] sinus problem	[ ] herpes or cold sores	[ ] alcohol or drug addiction

Have you been hospitalized in the past 5 years? If yes, when and for what reason? _____

_____

Are you being treated for any other medical condition not listed above? If yes, what: _____

_____

PLEASE SEE OTHER SIDE

Patient Name: _____

Dental History: Do you use:

[ ] dental floss
[ ] disclosing tablets
[ ] Peridex or Perioguard
[ ] Waterpik
[ ] mouth rinse
[ ] soft toothbrush
[ ] bleach guards
[ ] electric toothbrush
[ ] fluoride prescription
[ ] hard toothbrush
[ ] periostat perio pills
[ ] sports guard

Do you use a TMJ or brux guard? _____

Diet: Do you consume any of the following more than once a week?

[ ] candy
[ ] sweetened coffee or tea
[ ] cake, cookies or sweet desserts
[ ] gum with sugar
[ ] non-diet soda
[ ] dried fruit
[ ] Juice between meals

How often do you: brush your teeth _____ floss _____

Do your teeth or gums bother you? [ ] yes [ ] no. If yes, please explain: _____

_____

Do you ever notice mouth sores? _____

Are you happy with the appearance of your teeth? If not, why? _____

_____

Do you have any problems with your jaw joints (TMJ)? [ ] yes [ ] no. If yes, please explain: _____

_____

Do you have any dental concerns? If so, what are they? _____

_____

_____

Do you or have you had orthodontic treatment? [ ] yes [ ] no. If yes, name of Doctor: _____

Briefly explain treatment: _____

_____

_____

Do you play contact sports? [ ] yes [ ] no

Do you weight lift (clench when lifting)? [ ] yes [ ] no

Do you snore? [ ] yes [ ] no

Can you breathe through your nose? [ ] yes [ ] no

Do you wake up tired in the morning? [ ] yes [ ] no

Do you have sleep apnea? [ ] yes [ ] no

Do you use CPAP? [ ] yes [ ] no

Do you clench/grind your teeth? [ ] yes [ ] no

PATIENT OR GUARDIAN'S SIGNATURE: _____

Home phone number: _____ Cell phone number: _____ Work Phone: _____

THANK YOU