Please Update Medical and Dental History

Patient Name: ______________________ D.O.B.: ________ Date: ________

Physician: ______________________ Phone: ________

Date of last visit: ________ Reason: ______________________

Is the patient receiving medical care now? [ ] yes [ ] no If yes, please explain: ________

____

Medications:

Is the patient taking any medication(s) now? This includes prescription, over the counter medications, vitamins, and herbal remedies. If yes, please specify: ________

____

What is the purpose of these medications? ________

Does the patient have any drug allergies or sensitivities? [ ] yes [ ] no If yes, please specify: ________

____

Does the patient have a latex allergy? [ ] yes [ ] no

Any metal or jewelry allergy? [ ] yes [ ] no

Does the patient have any heart problems? [ ] yes [ ] no If yes, please specify: ________

____

Does the patient have a heart murmur? [ ] yes [ ] no

If yes, has the patient premedicated today? [ ] yes [ ] no

Does the patient have AIDS or a positive HIV test? [ ] yes [ ] no

Does the patient have any prosthetic joints - i.e., hip, knee? [ ] yes [ ] no

Tobacco History: Does or has the patient used tobacco products? [ ] yes [ ] no If yes:

What: ________ How much: ________ How long: ________

Are you interested in getting help to quit tobacco use? ________

Health History: Please check if the patient has, or has had:

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

Has the patient 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: Does the patient use:

[ ] dental floss
[ ] mouth rinse
[ ] fluoride prescription
[ ] disclosing tablets
[ ] soft toothbrush
[ ] hard toothbrush
[ ] peridex or perioguard
[ ] bleach guards
[ ] periostat perio pills
[ ] waterpik
[ ] electric toothbrush

Does the patient use a TMJ or brux guard? __________

Diet: Does the patient consume any of the following more than once a week?

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

How often do you: brush __________ 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 (TMJs)? [ ] yes [ ] no If yes, please explain:

____

____

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

____

____

Have you had any orthodontic treatment? ______________________________

If so, name of doctor ______________________________

PATIENT OR GUARDIAN'S SIGNATURE: ______________________________

Home/Cell Phone: ______________________________

Work Phone: ______________________________