# Medical History
## Restorative Dental

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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

**Patient's Name:** _____ **Date:** _____

**Oral Health History:**

When was the last time you saw a dentist: _____Dentist:_____
Are any of your teeth sensitive to hot, cold, pressure, or sweets:_____
How often do your gums bleed when you brush/floss: _____
Do your jaw joints click, pop, or cause pain: _____
Have you ever been told you have periodontal gum disease: _____
Are there areas in your mouth you avoid chewing:_____
Are you aware of any nighttime clenching or grinding of your teeth:_____
Do your teeth show signs of chipping and/or wear:_____
Have you ever had problems with past dental treatment:_____
Are you missing any teeth: _____How many?_____
Do you have a replacement for missing teeth:_____What?_____

**Medical Health History:**

Are you under a physician's care now? _____ If yes who: _____
Date last seen by physician: _____ Height: _____ Weight: _____
Have you been hospitalized within the last 5 years? _____ What for? _____
Have been hospitalized/had major surgery? _____ If yes for what:_____
Ever had serious head or neck injury? _____ If yes what/when: _____
Are you taking any medications, pills, or drugs? _____ If yes what:_____
Do you, or have you taken Phen-Fen or Redux? _____If yes when:_____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? _____
If yes when & what for: _____
Are you on a special diet? _____ If yes what: _____
Do you use controlled substances? _____ If yes what: _____
Do you use tobacco? _____

**Women:** are you….

Pregnant: _____ Due date: _____ Nursing: _____Taking Oral Contraceptives: _____

**Allergies:**

Are you allergic to any of the following:
Aspirin: _____ Penicillin: _____ Codeine: _____ Local Anesthetics: _____
Metal: _____ Latex: _____ Sulfa Drugs: _____ Acrylic: _____

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**Do you, or have you had, any of the following:**

☐Y☐N AIDS/HIV+
☐Y☐N Alzheimer's
☐Y☐N Anaphylaxis
☐Y☐N Anemia
☐Y☐N Angina
☐Y☐N Arthritis/Gout
☐Y☐N Artificial Joint
☐Y☐N Asthma
☐Y☐N Blood Disease
☐Y☐N Blood Transfusion
☐Y☐N Breathing Issues
☐Y☐N Bruise Easily
☐Y☐N Cancer
☐Y☐N Chemotherapy
☐Y☐N Chest Pains
☐Y☐N Cold Sores
☐Y☐N Fever Blisters
☐Y☐N Congenital Heart
☐Y☐N Convulsions
☐Y☐N Cortisone Meds
☐Y☐N Diabetes
☐Y☐N Drug Addiction
☐Y☐N Easily Wounded
☐Y☐N Emphysema
☐Y☐N Epilepsy/Seizures
☐Y☐N Excessive Bleeding
☐Y☐N Excessive Thirst
☐Y☐N Fainting/Dizziness
☐Y☐N Frequent Cough
☐Y☐N Frequent Diarrhea
☐Y☐N Frequent Headaches
☐Y☐N Genital Herpes
☐Y☐N Glaucoma
☐Y☐N Hay Fever
☐Y☐N Heart Attack
☐Y☐N Heart Murmur
☐Y☐N Heart Pacemaker
☐Y☐N Heart Trouble/Disease
☐Y☐N Hemophilia
☐Y☐N Hepatitis A
☐Y☐N Hepatitis B or C
☐Y☐N Herpes
☐Y☐N High Blood Pressure
☐Y☐N High Cholesterol
☐Y☐N Hives or Rash
☐Y☐N Hypoglycemia
☐Y☐N Irregular Heartbeat
☐Y☐N Kidney Problems
☐Y☐N Leukemia
☐Y☐N Liver Disease
☐Y☐N Low Blood Pressure
☐Y☐N Lung Disease
☐Y☐N Mitral Valve Prolapse
☐Y☐N Osteoporosis
☐Y☐N Pain in Jaw Joints
☐Y☐N Parathyroid Disease
☐Y☐N Psychiatric Care
☐Y☐N Radiation Treatment
☐Y☐N Recent Weight Loss
☐Y☐N Renal Dialysis
☐Y☐N Rheumatic Fever
☐Y☐N Rheumatism
☐Y☐N Scarlet Fever
☐Y☐N Shingles
☐Y☐N Sickle Cell Disease
☐Y☐N Sinus Trouble
☐Y☐N Spina Bifida
☐Y☐N Stomach Disease
☐Y☐N Stroke
☐Y☐N Swelling of Limbs
☐Y☐N Thyroid Disease
☐Y☐N Tonsillitis
☐Y☐N Tuberculosis
☐Y☐N Tumors or Growths
☐Y☐N Ulcers
☐Y☐N Venereal Disease
☐Y☐N Yellow Jaundice
☐Y☐N Abnormal Bleeding
☐Y☐N Allergies
☐Y☐N Antibiotic Premedication
☐Y☐N Bisphosphonates
☐Y☐N COPD
☐Y☐N Coumadin/Aspirin Therapy
☐Y☐N Drug/Alcohol Problem
☐Y☐N Kidney Disease
☐Y☐N Malignancy
☐Y☐N Psychiatric Problems
☐Y☐N Reflux/Heartburn
☐Y☐N Sexually Transmitted Disease

Have you ever had any serious illness not listed above? _____ What? _____
Do you have any reason why routine dental procedures might pose a risk to you, the dental staff, or other patients? ____
If yes, please explain: _____
Is there anything important about your medical condition that we have not asked? _____
If yes, please explain:_____

Any additional comments or remarks:_____

_____

_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

Signature: _____ Date: _____