PATIENT DENTAL HEALTH HISTORY

Name: _____ **DOB:** _____

The following conditions MAY require **PREMEDICATION PRIOR** to dental treatment. CIRCLE any of which you have been diagnosed/treated:

HEART MURMER	ARTIFICIAL HEART VALVE	STENTS	JOINT REPLACEMENT
MITRAL VALVE	RHEUMATIC FEVER	ENDOCARDITIS	Joint date: _____

Name of Medical Doctor: _____ Phone Number: _____

Name of Cardiologist: _____ Phone Number: _____

Pharmacy Name: _____ City _____ State _____

Are you currently under Physician's Care? Yes No If yes, describe: _____

Do you have any dental concerns/problems at this time? _____

_____

Are you allergic to any of the following **Aspirin** **Penicillin** **Codeine** **Local Anesthetics**
Latex **Sulfa Drugs** **Amoxicillin** **Ibuprofen** **Other** _____

CURRENT MEDICATIONS (prescriptions/herbals/supplements/vitamins)

MEDICATIONS	DOSAGE	FREQUENCY

Have you ever been treated for Osteoporosis (Fosamax, Boniva, Actonel)? YES NO

Have you had Cancer Treatment with Aredia, Bonefos or Zomets? YES NO

Are you taking any blood thinners including Aspirin? **YES** **NO**

PATIENT/FAMILY HISTORY – please indicate if you or any family members currently have or have had any of the following health issues:

Health Issue	You	Family	Health Issue	You	Family
A-Fib			Gastrointestinal Disease		
Alzheimer			Heart Disease/Attack		
Anemia			Heart Surgery		
Angina Pectoris			Hepatitis A B C		
Arthritis			High Blood Pressure		
Asthma			HIV		
Autoimmune Disease			Kidney Disease		
Bleeding Problems			MRSA		
Cancer Type:			Multiple Sclerosis		
Chemical Dependency			Pacemaker		
Chemotherapy			Parkinson		
Congestive Heart Failure			Psychiatric Treatment		
Dementia			Radiation Head/Neck		
Depression			Sjogrens Disease		
Diabetes			Sinus Trouble		
Dialysis			Sleep Apnea		
Dry Mouth			Stroke		
Emphysema			TMJ		
Epilepsy/Seizures			Tuberculosis		
Fibromyalgia			Thyroid		

Do you have any disease, condition, or problems not listed above that you think I should know about? Yes No
Explain: _____

TOBACCO:

Tobacco User Yes No Former Type: _____ Amount: _____ Years: _____
Are you interested in quitting tobacco? Yes No

DENTAL HEALTH INFORAMTION:

Name of previous Dentist: _____ Date of last Exam: _____
How often do you brush your teeth? _____ How often do you floss? _____
What type of beverages do you typically drink? _____
What are some typical foods you eat between meals? _____
How often do you suck on hard candy, cough drops, and mints? _____
Do you use fluoride toothpaste? Yes No
Primary source of water? City Well Bottled

PATIENT DENTAL HISTORY:

Family History of extensive decay	Yes	No	Dry mouth or excessive thirst	Yes	No
Treatment for Periodontal Disease	Yes	No	Sensitive Teeth Hot/Cold	Pressure	Sweets
Have you had Orthodontics (braces)	Yes	No	Bad Breath/Bad Taste	Yes	No
Have you had Oral Surgery	Yes	No	Cold Sores/Blisters/Oral Lesions	Yes	No
Do you have Dental Implants	Yes	No	Sore, bleeding gums	Yes	No
Treatment of TMJ Disorder	Yes	No	Loose Teeth	Yes	No
Difficulty Chewing	Yes	No	Food catches between teeth	Yes	No
Teeth/fillings break frequently	Yes	No	Clenching or grinding habit	Yes	No
Clicking, popping or snapping in jaw	Yes	No	Jaw pain	Yes	No
Do you wear denture(s) or partial(s)	Yes	No			
If yes, date of placement _____					

Rate your dental anxiety level: ***(low) 1 2 3 4 5 (high)***
How do you feel about your smile? _____

Authorize to Release:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform the dental office of any changes in my medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third-party payers and/or healthcare providers. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any actions they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Initial History Reviewed: Doctor Signature Date

Annual Update	Changes	Patient Initial	Provider Signature