Designs in Dentistry

Confidential Dental & Medical History

Patient Name: _____ Date of Birth_____
Last First MI ☐ Male ☐ Female

Please circle Yes or No to each of the following questions or conditions:

Yes No Do you have a specific dental problem? Please describe: _____
Yes No Do you think you have decay or gum disease? _____
Yes No Do your gums bleed? Describe: _____
Yes No Do you use tobacco? Describe: _____
Yes No Do you Vape? Describe: _____
Yes No Do you dislike the appearance or color of your teeth? Describe_____
Yes No Have you ever had orthodontic treatment (tooth straightening)? _____
Yes No Do you ever clench or grind your teeth? Describe _____
Yes No Do you suffer from (experience) a dry mouth? _____
Yes No Do you experience clicking, popping or discomfort in your jaw joints (TMJ)? Describe _____
_____
Yes No Are you nervous or anxious about having dental treatment? _____
Yes No Have you ever had a bad dental experience? Describe _____
Yes No Are you interested in using nitrous oxide gas? _____
How do you take care of your teeth and gums? Describe _____

Do you or have you ever had:

Yes No Congenital heart conditions
Yes No Heart pacemaker
Yes No Heart surgery/stents
Yes No Artificial heart valve
Yes No Stroke
Yes No High blood pressure
Yes No Low blood pressure
Yes No Anemia
Yes No Blood transfusion
Yes No Hemophilia/ Uncontrolled bleeding
Yes No Acid Reflux
Yes No HIV positive (AIDS)
Yes No Bruise easily
Yes No Hypoglycemia
Yes No Shortness of breath
Yes No Fainting or dizziness
Yes No Allergies
Yes No Latex allergy
Yes No Asthma
Yes No Sinus conditions
Yes No Emphysema/COPD
Yes No Frequent cough
Yes No Tuberculosis
Yes No Recent weight loss
Yes No Phen-Fen/ Redux use
Yes No Mental health disorder
Yes No Alzheimer's/Dementia
Yes No Drug/alcohol addiction
Yes No Anxiety/panic disorder
Yes No Cold sores
Yes No Diabetes
Yes No Kidney disease
Yes No Swelling of hands/ feet
Yes No Hepatitis
Yes No Jaundice
Yes No Epilepsy or seizures
Yes No Cancer
Yes No Radiation treatments
Yes No Chemotherapy
Yes No Artificial joint/knee/hip
Yes No Lupus
Yes No Arthritis/gout
Yes No Rheumatism
Yes No Glaucoma
Yes No Cortisone medication
Yes No Thyroid disease
Yes No Para-thyroid disease
Yes No Osteoporosis/ Osteopenia

Name of Physician: _____ Phone:(____) _____
Are you presently under the care of your physician? Yes No If Yes, please explain: _____
_____
Have you been admitted to a hospital or needed emergency care during the past two years? Yes No If Yes, please explain:
_____
Please list all prescription medication(s) you are taking: _____ _____ _____
_____ _____ _____ _____ _____
Do you or have you taken bisphosphonates (i.e., Fosamax, Boniva) for cancer treatment or osteoporosis? _____ Yes No
Do you use "recreational or street" drugs? _____ Yes No
Are you allergic to any medications or substances? Yes No If Yes, please list: _____ _____
_____ _____ _____ _____ _____
Have you ever had any complications following dental treatment? If Yes, please explain _____
_____
Do you have any health conditions that need further clarification? _____ Yes No
Do you wish to speak to the dentist privately about any problem or condition? _____ Yes No

Female patients:
Are you pregnant? Yes No If Yes, due date? _____
Are you taking birth control pills or hormone replacement therapy? Yes No _____

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I have a change in my health, medical conditions or medications I will inform the doctor(s) and/or dental hygienist(s). I have received a copy of ***The Facts About Fillings*** as required by the Dental Board of California.

Signature of patient, parent or guardian	**Relationship (other than self)**	**Date**	**Doctor's Signature/Date**

Date	*Changes to Health History*	*Patient Signature*	*Hygienist/Doctor's Signature*