Dental and Medical History

Date:

PERSONAL INFORMATION

Patient first name:

Last name:

Email:

Phone Number:

Address:

City:

State / Province:

Postal / Zip Code:

Birth Date (DD/MM/YYYY):

Gender:

Male

Female

Non-Binary

Emergency contact name:

Relationship to you:

Emergency contact email:

Emergency contact phone number:

DENTISTRY

Current dentist's name:

Last name:

Dentist's email:

Dentist's phone:

DENTISTRY

Last visit date (DD/MM/YYYY):

Last cleaning (DD/MM/YYYY):

Do you have any dental problems now? If yes, please describe:

Dental Questionnaire	YES	NO
Do you have any missing teeth?		
Do you have any broken, chipped or damaged teeth?		
Are you happy with the appearance of your smile?		
Do you floss regularly?		
Do you have areas of receded gums?		
Do your gums bleed?		
Does gum disease or periodontal disease run in your family?		
Have you ever had a periodontal treatment?		
Are your teeth hot/cold sensitive?		
Do you get food caught between your teeth?		
Are your teeth sensitive to sweets?		
Do you drink coffee, tea or red wine?		
Do you have tired jaws?		
Do you clench or grind your teeth?		
Do you have a night guard or bite splint?		
Have you ever had an oral surgery?		
Have you had any injury to your face/jaw?		
Have you ever received radiation to your jaw?		

Dental Questionnaire	YES	NO
Do you have popping or clicking in the jaw?		
Do you chew on pens, fingernails, etc?		
Do you have orthodontics / braces?		
Are you fearful of the dentist?		

MEDICAL

Current physician's name:

Last name:

Physician's email:

Physician's phone:

Medical Questionnaire	YES	NO
Diabetes?		
Arthritis?		
Rheumatic Fever?		
Heart Disease?		
Heart surgery or disease?		
Heart attack or strokes?		
Heart murmur?		
Artificial Heart Valve/ Pacemaker?		
Mitral valve prolapse?		
High blood pressure?		

Medical Questionnaire	YES	NO
Low blood pressure?		
Blood transfusion?		
Hemophilia or blood disorder?		
Mitral valve prolapse?		
Kidney disease?		
Hepatitis A, B?		
Jaundice or liver disease?		
Thyroid disorder?		
Tuberculosis or lung disease?		
Emphysema or asthma?		
Hay fever or airborne allergies?		
Headaches or migraines?		
Neurological disorders?		
Convulsions or epilepsy?		
Dizzy spells or fainting?		
Psychiatric or psychological care?		
Depression?		
Cancer?		
Radiation or Chemotherapy?		
Tumors?		
Stomach, intestinal, or colon disorders?		
Cortisone or steroid therapy?		

Dental Questionnaire	YES	NO
Artificial joints (hip, knee, etc)?		
Bruise easily?		
Possess the HIV or AIDS antibody?		
Excessive or Prolonged Bleeding?		
Venereal disease?		
Cold sores or fever blisters?		
Alcoholism?		

Do you have any other disease/condition not listed above?

Are you allergic to any of the following medications:

Aspirin: Yes No Penicillin: Yes No Sulfas: Yes No

Any other type of medication: If yes, please specify:

Yes No

Have you presented any abnormal reactions to dental anesthesia? Yes No

If yes, what kind of reaction?

Have had any of the following cardiac procedures performed on you?

Valvular prosthesis: Yes No Bacterial endocarditis: Yes No

Heart disease/ Cyanotic complex: Yes No

Are you currently taking any medication, drugs, pills or herbal remedies, including regular doses of aspirin? Yes No

If yes, please provide a list all medications and dosages:

Are you aware of having an allergic (or adverse) reaction to any substance or medication?

Yes ☐ No ☐

If yes, please specify:

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes ☐ No ☐

If yes, please specify:

Have you been a patient in the hospital during the past five years? Yes ☐ No ☐

In order to prescribe medications to effectively manage your pain levels, do you use or have you ever used recreational drugs? Yes ☐ No ☐

How often do you consume alcoholic beverages?

Never ☐ Once a month ☐ 2-3 times a week ☐ Once a week ☐ Everyday ☐

Do you or have you ever smoked or used tobacco? Describe type, frequency and duration:

WOMEN ONLY

Are you pregnant? Yes ☐ No ☐

If yes, are you breastfeeding? Yes ☐ No ☐

Do you suffer from a menstrual period disorder? Yes ☐ No ☐