Please **CIRCLE** the appropriate response next to each question below: Yes (Y), No (N), Don’t Know (?)

**Medical History**

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

1. **Breathing Problems?**
   a. Asthma
   b. Emphysema
   c. Bronchitis
   d. Tuberculosis
   e. Shortness of breath
   f. Sleep Apnea or use a CPAP
   g. Other breathing problems
   Explain

2. **Heart or circulation problems?**
   a. High blood pressure
   b. Heart Attack
   c. Angina or chest pain
   d. Irregular heart beat
   e. Rheumatic Fever
   f. Heart murmur
   g. Mitral Valve Prolapse
   h. Damage to heart valves
   i. Heart valve replacement
   j. Pacemaker
   k. Cardiac Stent/other device
   l. Congestive heart failure
   m. Swollen ankles
   n. Other heart or circulation problems
   Explain

3. **Muscle, bone or skin problems?**
   a. Arthritis
   b. Osteoporosis, Osteopenia bone loss
   c. Artificial joint placement
   d. Hives or skin rash
   e. Skin cancer
   f. Back problems
   g. Other muscle, bone or skin disease
   Explain

4. **Kidney or urinary problems?**
   a. Kidney Disease
   b. Dialysis
   c. Frequent urination
   d. Other kidney problems
   Explain

5. **Nervous System problems?**
   a. Stroke/Transient ischemic attack (TIA)
   b. Fainting Spells
   c. Convulsions, seizure or epilepsy
   d. Other nervous system problems
   Explain

6. **Head and neck problems?**
   a. Nose or sinus problems
   b. Swollen glands
   c. Oral Cancer
   d. Impairment of hearing, sight or speech
   e. Frequent or severe headaches
   f. Other head and neck problems
   Explain

7. **Hormone or gland problems?**
   a. Thyroid disease
   b. Diabetes
   c. Adrenal or pancreatic disease
   d. Addison’s disease
   e. Steroid use
   f. Any other hormone/gland disease
   Explain

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Signature: ___________________________ Date: ___________________________
8. **Stomach, liver or intestinal problems?**
   a. Liver disease Y N ?
   b. Hepatitis Y N ?
   c. Acid Reflux (GERD) Y N ?
   d. Ulcers Y N ?
   e. Other stomach or intestinal problems Y N ?
   f. Other liver problems Y N ?

9. **Allergic reactions or other problems?**
   a. Seasonal allergies Y N ?
   b. Allergy, reaction or intolerance
      Penicillin Y N ?
      Erythromycin Y N ?
      Codeine Y N ?
      Latex Y N ?
      Local anesthetic Y N ?
      Foods/flavoring Y N ?

10. **Blood or immune system problems?**
    a. Cancer of any type Y N ?
    b. Organ or bone marrow transplant Y N ?
    c. Lupus Y N ?
    d. Multiple sclerosis Y N ?
    e. Anemia Y N ?
    f. Hemophilia Y N ?
    g. AIDS/HIV Y N ?
    h. Increased bleeding or nosebleeds Y N ?
    i. Are you taking blood thinners Y N ?
    j. Chemotherapy or radiation treatment Y N ?
    k. Other blood/immune problems Y N ?

11. **What Medications or other substances are you taking or have you taken in the past 2 months?**
    a. Please list all prescriptions and non-prescription drugs including aspirin, birth control pills, herbal medications or other supplements. Write “NONE” if you are not taking any medications or substances. ________________________________
        ____________________________________________________________
        ____________________________________________________________
        ____________________________________________________________

    b. Have you ever taken or are you taking medicine for osteopenia, osteoporosis, bone loss Y N ?
       i. **Example:** Fosamax®, Actonel®, Boniva®, Reclast®, Evista®, Forteo®, Prolia®, Miacalix®, Fortical®

    c. Are you currently taking a **blood thinner**? Y N ?
       i. **Example:** Coumadin/Warfarin®, Eliquis®, Pradaxa®, Xarelto®, Heparin®, Aspirin®, Plavix®/Clopidogrel®
       ii. If taking Coumadin/Warfarin® what was your last INR? ________________________________

    d. When was your last visit to a physician (medical doctor)?______________________________

    e. Please provide your physician’s (medical doctor’s) contact information.
       i. **Name:** ____________________________________________
       ii. **Location:** _________________________________________
       iii. **Telephone Number:** ________________________________

Signature: ________________________________ Date: ________________________
f. Please provide your pharmacy’s contact information.
   i. Name: _____________________________
   ii. Location: ___________________________
   iii. Telephone Number: _______________________

12. Personal History
   a. Have you ever been hospitalized, had major surgery or been seriously hurt?  Y    N   ?
   i. List: __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

   b. History of any sexually transmitted diseases (syphilis, gonorrhea, herpes, etc. HIV)?  Y    N   ?

   c. Do you need any special accommodations for dental treatment?  Y    N   ?
   i. Explain _______________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

   d. Are you pregnant or breast feeding?  Y    N   ?

   e. Have you ever used tobacco products?  Y    N   ?

   f. Are you currently using tobacco products?  Y    N   ?
   Type and how much? _____________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

   g. How many alcohol containing drinks do you consume a week? _____________

   h. Do you use or have you used recreational drugs?  Y    N   ?

   i. Have you ever had a problem with drugs and/or alcohol?  Y    N   ?

   j. Do you have mental health problems?  Y    N   ?

OFFICE USE ONLY

Reviewed By: ___________________________________________ Date: __________
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DENTAL HISTORY

1. What is the reason for your dental visit? 

Your Current Dental Health

2. Have you had a recent toothache? Y N ?
3. Are your teeth sensitive to hot, cold or pressure? Y N ?
4. Do you have bleeding gums? Y N ?
5. Do you have trouble chewing? Y N ?
6. Do you experience dry mouth? Y N ?
7. Do you have sores in or around your mouth? Y N ?
8. Do you clench or grind your teeth? Y N ?
9. Have you ever worn a bitesplint/nightguard? Y N ?

10. Please circle the amount of sugar in your diet? Small Moderate High

11. When was the last time your teeth were cleaned in a dental office? 

12. How often do you brush? __________________________ Electric toothbrush Y N ?

13. How often do you floss? __________________________ 

14. Are you satisfied with the appearance of your teeth? __________________________

15. If not, what is one thing you would like to change about your teeth? __________________________

Previous Dental Treatment

16. Have you ever had any problems following dental treatment? Y N ?
   a. If yes, please explain 

17. Have you ever had a “deep cleaning” or gum surgery? Y N ?
18. Have you ever had orthodontic treatment to straighten your teeth? Y N ?
19. Have you ever had extraction (pulling) of any teeth? Y N ?
20. Have you ever had endodontics (root canals) on any teeth? Y N ?
21. Have you had any missing teeth replaced by a removable denture, fixed bridge, or an implant? Y N ?
22. Have you ever had a bad or unusual reaction to local anesthetic? Y N ?
23. Have you ever had severe injury/surgery to your face, teeth, lips, or jaws? Y N ?
24. How do you feel about going to the dentist? No Problem Apprehensive Scared

Jaw Joint Health

25. Do you have difficulty opening your mouth as wide as you would like? Y N ?
26. Do your jaw joints or muscles hurt? Y N ?
27. Does your jaw click, pop or lock? Y N ?

Signature: __________________________ Date: __________________________