Medical History (New Patient Form)

Patient's Name: _____

Primary Care Doctor: _____

When was the last time you saw a doctor? _____

If so, why? _____

Have you been hospitalized in the last two years? No ◯ Yes ◯

If so, why? _____

Please list all medications/drugs/vitamins/herbs that you are taking:

_____

_____

Have you ever had an adverse reaction or allergies to any medication or substance?

- ☐ **Aspirin**
- ☐ **Codeine**
- ☐ **Dental Anesthetics**
- ☐ **Erythromycin**
- ☐ **Iodine**
- ☐ **Latex**
- ☐ **Nitrous Oxide**
- ☐ **Metals**
- ☐ **Penicillin**
- ☐ **Peanuts/Milk/Food Allergies**
- ☐ **Sulfa Drugs**
- ☐ **Tetracycline**
- ☐ **Valium or other Sedatives**
- ☐ **Others** _____

Please check all that apply to your medical history:

Heart/Circulation/Autoimmune Disorders:

- ☐ **Bleeding Problem/Anemia**
- ☐ **Congenital Heart Defect**
- ☐ **Heart/Valve Surgery**
- ☐ **Heart Attack/ Stroke/TIA**
- ☐ **Heart Murmur**
- ☐ **High Blood Pressure (____/____)**
- ☐ **HIV/AIDS**
- ☐ **Autoimmune Disorder (_____)**

Do you pre-medicate with antibiotics for dental procedures? No ◯ Yes ◯
Have you ever been told you needed to pre-medicate? No ◯ Yes ◯

Lungs/Breathing:

☐ **Asthma**
(Do you carry a rescue inhaler? No ◯ Yes ◯)
☐ **COPD/Emphysema**
☐ **Dry Mouth**
☐ **Lung Disease**
☐ **Sleep Apnea**
(Do you use a CPAP? No ◯ Yes ◯)
☐ **Snoring**
☐ **Tuberculosis**

Joints/Bones:

☐ **Arthritis**
(Type of Arthritis _____)
☐ **Artificial Joint**
(Do you pre-medicate for dental procedures? No ◯ Yes ◯)
☐ **Osteoporosis**
(Do you take medication to correct? No ◯ Yes ◯)

Metabolic Disease/ GI:

☐ **Acid Reflux/Ulcers**
☐ **Diabetes Type I**
☐ **Diabetes Type II**
☐ **Frequent Thirst**
☐ **Frequent Urination**
☐ **Frequent Hunger**
☐ **Hypoglycemia**
☐ **Hepatitis A**
☐ **Hepatitis B**
☐ **Hepatitis C**
☐ **Kidney Disease**
☐ **Liver Disease**
☐ **Thyroid Disease**
☐ **Transplant _____**

Diabetics: Do you know your most recent A1C number? _____%
Normal range: 5.5-6.0% and below

_____

Dental History

What are your current dental concerns? _____
_____

How long has it been since your last dental visit? _____
What was done? _____

Are you happy with the appearance of your teeth?
Yes ◉ **No** ○
Would you like them to be straighter?
Yes ◉ **No** ○
Would you like them to be whiter?
Yes ◉ **No** ○

How often do you brush? _____
How often do you floss? _____
How often do you use other aids? _____

Have you ever avoided regular dental care?
Yes ○ **No** ○
Why? _____

Do you feel like you might clench or grind when you sleep or experience stress?
Yes ○ **No** ○

Have you been told in the past that you need a nightguard or occlusal guard?
Yes ○ **No** ○

Have you been told in the past that you have gum disease or periodontal disease?
Yes ○ **No** ○

Have you had previous gum treatments, scaling and root planing or more frequent professional cleanings?
Yes ○ **No** ○

What are your dental expectations?
_____
_____

Shall we request records from your previous dentist?
Yes ○ **No** ○

Name of last dentist? _____

City, State? _____

Submit