

Patient Medical and Dental History:

Name: _____ Gender: M / F DOB: _____ Age: _____
 Phone #: _____ Height (ft): _____ Weight (lbs): _____
 General practitioner's name: _____ Phone #: _____ Last Visit: _____
 Do you see any other doctors/ specialty providers?..... Y / N
 If yes, who and why? _____
 Do you see any doctors for pain management?..... Y / N
 If yes, who and why? _____
 Have you ever been hospitalized for any illness or surgical operation? Y / N
 If yes, when and why? _____
 Have you ever been told to take an antibiotic before going to the dentist? Y / N
 If yes, why and what? _____
 Have you ever been given anesthetic for a dental cleaning known as scaling and root planing?..... Y / N
 Do you consider yourself nervous when it comes to dental treatment?..... Y / N
 Do you think your teeth are affecting your general health?..... Y / N
 Have you or anyone in your family had any previous periodontal treatment? Y / N
 If yes, when and what? _____
 Are you happy with the appearance of your smile? Y / N
 Have you been told or have a history of clenching/grinding your teeth? Y / N

Allergies

List any allergies and reactions: _____

Medications & supplements (please list ALL medications and supplements, including doses and frequency)

☐ None

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Have you ever taken any bone altering medications in the past? Y / N

If yes, please circle one.

Fosamax Boniva Zometa Aredia Didronel Reclast Prolia Xgeva

Other (list): _____

When was your last injection? _____ or N/A How long have you been on this medication? _____

Surgical and Anesthesia History

Have you ever had surgery before? Y / N

Please list _____

Have you ever had anesthesia before? Y / N

If yes, did you have any complications from anesthesia that you know of? (list:) _____

Has anyone else in your family had a problem with anesthesia? Y / N

Heart / Cardiovascular	Lungs / Respiratory
High blood pressure..... Y / N	Asthma.....Y / N
Heart attack / MI..... Y / N	Inhaler Y / N
Heart disease..... Y / N	COPD..... Y / N
Valve problems..... Y / N	Emphysema.....Y / N
Valve replacement..... Y / N	Do you snore?.....Y / N
Pacemaker or defibrillator..... Y / N	Sleep Apnea...(Central or Obstructive)..... Y / N
Chest pain / angina / palpitations..... Y / N	CPAP..... Y / N
Recently lost / gained weight without trying..... Y / N	Chronic cough Y / N
Shortness of breath..... Y / N	Recent cold or flu..... Y / N
Heart failure..... Y / N	Recent travel out of the country.....Y / N
Rheumatic Fever..... Y / N	Cigarette / cigars / smokeless / vaping Y / N
Heart infection / endocarditis..... Y / N	How much? _____ packs per day..... How long? _____ years
Peripheral Vascular Disease..... Y / N	History of tuberculosis (TB).....Y / N
Other? Please list: _____	Pulmonary hypertension..... Y / N
If yes, please describe and details of event: _____	Difficulty breathing? Y / N
_____	Use oxygen at home?..... Y / N
_____	Other? Please list: _____
Head / Neurology/ Musculoskeletal	Stomach / Bowel / Kidney/ Lab values
Stroke..... Y / N	Acid reflux / heart burn / peptic ulcer disease..... Y / N
Seizures Y / N	Irritable Bowel Syndrome Y / N
Debilitating headaches Y / N	History of C-Diff..... Y / N
Contact lenses or glasses Y / N	Diabetes Y / N
Glaucoma Y / N	Last A1C _____
Fainting Y / N	Thyroid problems Y / N
Parkinson's Y / N	Prescribed steroids Y / N
Multiple Sclerosis Y / N	Kidney problems..... Y / N
Muscle disorders Y / N	Liver problems Y / N
Arthritis..... Y / N	Other? Please list: _____
Joint Replacement Y / N	Are you currently taking any form of weight loss drug / GLP-1 such as ozempic, mounjaro?.....Y / N
Peripheral neuropathy Y / N	Has your doctor recommended to avoid NSAIDS?.....Y / N
Other? Please list: _____	
Blood Related/ Infectious/ Disease	Miscellaneous
Blood disorder.....Y / N	How much alcohol per week_____ or N/A
Anemia Y / N	Use of recreational drugs Y / N
Cancer..... Y / N	Autoimmune disease Y / N
Type:_____	Type:_____
Radiation/Chemo (when):_____	Organ Transplant.....Y / N
Sickle cell disease or trait Y / N	Other? Please list: _____
Infectious Disease (MRSA, VRE, etc.) Y / N	WOMEN
Hepatitis....Circle Type: A B C Y / N	Are you taking birth control / contraceptives?.....Y / N
HIV or AIDs?..... Y / N	Is there a chance you could be pregnant?.....Y / N
Other? Please list: _____	Are you breastfeeding?..... Y / N
	Have you reached menopause?..... Y / N
	Other? Please list: _____

Authorization and Release: I certify that I have read and understand the above information, and, to the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health and could jeopardize my treatment and healing. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners.

Signature: _____ Date: _____