



Medical and Dental History

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Your health affects your dental care. Please answer every question. Your answers are kept confidential.

Patient name (first and last)

Date of birth (MM/DD/YYYY)

Your physician

Physician name

Phone

Date of last physical exam

Are you currently under a physician's care?

☐ Yes

☐ No

If yes, for what?

Have you been hospitalized or had surgery in the past 5 years?

☐ Yes

☐ No

If yes, please explain

Has a physician or dentist told you to take antibiotics before dental treatment (premedication)?

☐ Yes

☐ No

If yes, for what condition?

Medications

Include prescriptions, over-the-counter medicines, vitamins and supplements.

☐ I do not take any medications

Medication	Dose	How often	Reason

Allergies

Check any you are allergic to.



- | | | |
|---|--|---|
| ☐ No known allergies | ☐ Latex | ☐ Codeine or other opioids |
| ☐ Penicillin | ☐ Local anesthetics (numbing) | ☐ Metals (such as nickel) |
| ☐ Other antibiotics | ☐ Aspirin or ibuprofen (NSAIDs) | ☐ Other (list below) |

Other allergies and the reaction you had

Medical conditions

Check any you have now or have had in the past.

- | | | |
|---|---|--|
| ☐ Heart disease | ☐ Blood thinners | ☐ Cancer |
| ☐ Heart attack | ☐ Anemia | ☐ Radiation or chemotherapy |
| ☐ Artificial heart valve | ☐ Diabetes | ☐ Osteoporosis medication* |
| ☐ Congenital heart defect | ☐ Thyroid disease | ☐ Artificial joint |
| ☐ Infective endocarditis | ☐ Asthma or COPD | ☐ Sleep apnea |
| ☐ Pacemaker or defibrillator | ☐ Kidney disease | ☐ Anxiety or depression |
| ☐ High blood pressure | ☐ Liver disease or hepatitis | ☐ Acid reflux (GERD) |
| ☐ Low blood pressure | ☐ HIV / AIDS | ☐ Tobacco or vaping |
| ☐ Stroke | ☐ Tuberculosis | ☐ Alcohol use |
| ☐ Bleeding disorder | ☐ Seizures or epilepsy | ☐ Recreational drug use |

* Such as bisphosphonates (Fosamax, Boniva, Reclast) or denosumab (Prolia). Please tell us even if you stopped taking it.

Other conditions or details

Women: are you pregnant or nursing?

☐ Yes ☐ No

If pregnant, how many weeks?

Dental history

What would you like us to help you with?

Check any that apply to you:

- | | |
|--|--|
| ☐ Sensitive teeth (hot, cold, sweets) | ☐ Had braces or aligners |
| ☐ Bleeding gums | ☐ Nervous about dental visits |
| ☐ Jaw pain, clicking or popping | ☐ Bad past dental experience |
| ☐ Clenching or grinding | ☐ Unhappy with my smile |

Date of last dental X-rays

Date of last cleaning



Anything else you would like the dentist to know?

Signature

I certify that I have answered these questions accurately to the best of my knowledge. I will tell the office about any changes to my health or medications.

Signature of patient or parent/guardian

Date

Printed name

Relationship to patient

For office use only

Reviewed by (dentist)

Date

History update date

Patient initials

Dentist initials