Designs in Dentistry

Confidential Dental & Medical History

Patient Name: _____ Date of Birth_____
Last First MI ☐ Male ☐ Female

Previous Dentist: _____ Date of Last Dental Visit: _____

Please circle Yes or No to each of the following questions or conditions:

Yes No Do you have a specific dental problem? Please describe: _____
Yes No Do you think you have decay or gum disease? _____
Yes No Do your gums bleed? Describe: _____
Yes No Do you use tobacco? Describe: _____
Yes No Do you dislike the appearance or color of your teeth? Describe_____
Yes No Have you ever had orthodontic treatment (tooth straightening)? _____
Yes No Do you ever clench or grind your teeth? Describe _____
Yes No Do you experience clicking, popping or discomfort in your jaw joints (TMJ)? Describe _____
_____
Yes No Are you nervous or anxious about having dental treatment? _____
Yes No Have you ever had a bad dental experience? Describe _____
Yes No Are you interested in using nitrous oxide gas? _____
How do you take care of your teeth and gums? Describe _____

Yes No Chest Pain	Yes No HIV positive (AIDS)	Yes No Recent weight loss	Yes No Hepatitis
Yes No Heart Conditions	Yes No Bruise Easily	Yes No Phen-Fen/ Redux use	Yes No Jaundice
Yes No Heart Murmur	Yes No Sickle Cell Anemia	Yes No Mental Health Disorder	Yes No Epilepsy or seizures
Yes No Rheumatic Fever	Yes No Hypoglycemia	Yes No Alzheimer's/Dementia	Yes No Cancer
Yes No Heart Lesions	Yes No Lung Disease	Yes No Drug/alcohol addiction	Yes No Radiation treatments
Yes No Mitral Valve Prolapse	Yes No Shortness of Breath	Yes No Anxiety/panic disorder	Yes No Chemotherapy
Yes No Heart Pacemaker	Yes No Fainting or Dizziness	Yes No Cold Sores	Yes No Artificial joint/knee/hip
Yes No Heart Surgery	Yes No Allergies	Yes No Fever blisters	Yes No Implants
Yes No Artificial Heart Valve	Yes No Scarlet Fever	Yes No Herpes	Yes No Lupus
Yes No Blood Disorder	Yes No Asthma	Yes No Venereal Disease	Yes No Arthritis/gout
Yes No High Blood Pressure	Yes No Hay fever	Yes No Diabetes	Yes No Rheumatism
Yes No Low Blood Pressure	Yes No Sinus conditions	Yes No Excessive Thirst	Yes No Glaucoma
Yes No Anemia	Yes No Emphysema	Yes No Kidney Disease	Yes No Cortisone medication
Yes No Blood transfusion	Yes No Frequent cough	Yes No Swelling of Hands/Feet	Yes No Thyroid Disease
Yes No Hemophilia/ Uncontrolled bleeding	Yes No Tuberculosis	Yes No Stroke	Yes No Para-thyroid Disease

Name of Physician: _____ Phone:(____)_____
Are you presently under the care of your physician? ☐ Yes ☐ No If Yes, please explain: _____
_____
Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No If Yes, please explain:
_____
Please list all prescription medication(s) you are taking: _____
Do you use "recreational or street" drugs? ☐ Yes ☐ No_____
Are you allergic to any medications or substances? ☐ Yes ☐ No If Yes, please list: _____
Have you ever experienced a reaction to latex gloves or latex products? ☐ Yes ☐ No_____
Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain _____
_____
Female patients:
Are you pregnant? ☐ Yes ☐ No If Yes, due date?_____
Are you taking birth control pills or hormone replacement therapy? ☐ Yes ☐ No_____
Do you have any health conditions that need further clarification? ☐ Yes ☐ No_____
Do you wish to speak to the dentist privately about any problem or condition? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have a change in my health, medical conditions or medications I will inform the doctor(s) and/or dental hygienist(s). I have received a copy of *The Facts About Fillings* required by the Dental Board of California.

Signature of patient, parent or guardian **Relationship (If other than self)** **Date**

Medical up-date – For Office Use Only

Date	*Changes*	*Dr/Hyg's Signature*	*Date*	*Changes*	*Dr/Hyg's Signature*