Patient's Name:_____ Date:_____

Dental History:

Date of last dental visit:_____ Reason for today's visit:_____
Are you nervous about dental treatment?_____ Do you have any dental concerns?_____
Have you been diagnosed with gingivitis/periodontal disease?_____ Do your gums bleed, feel tender or irritated?_____
Are your teeth sensitive?_____ If yes, to what? Sweets:_____ Hot:_____ Cold:_____ Pressure:_____
Have you had orthodontics?_____Do you wear any type of occlusal guard or retainer?_____
Are you unhappy with the appearance of your teeth?_____
Has a physician or dentist recommended that you **pre-medicate** with an antibiotic prophylaxis before having dental work done?_____

Medication History: List all Medications you are currently taking below, including over-the-counter medicine, vitamins/supplements and herbs. Include information about how much and how often.

_____
_____
_____

Allergies: Please mark any of the following medical allergies you have.

_____ **None**	_____ Codeine	_____ Latex	_____ Penicillin
_____ Aspirin	_____ Other Narcotics	_____ Local anesthetics	_____ Other Antibiotics
_____ Barbiturates	_____ Iodine	_____ Sulfa Drugs	_____ Other:_____

Medical History: Please mark any of the following which you have had or have at present.

Heart Health
_____ Heart Disease
_____ Heart Murmur
_____ High Blood Pressure
_____ Pacemaker
_____ Heart Attack
_____ Stroke
_____ Heart Medications
_____ Other

Blood Health
_____ Anemia
_____ Hemophilia
_____ Low Blood Pressure
_____ Blood Thinners
_____ Other
_____ Immuno-compromised

Respiratory Health
_____ Asthma/COPD
_____ Bronchitis/Emphysema
_____ Sinus Trouble
_____ Tuberculosis

Cancer
_____ Chemotherapy
_____ Radiation
Type:_____

Autoimmune Disease
_____ AIDS/HIV
_____ Lupus
_____ Other

Digestive Health
_____ Gastrointestinal Disease
_____ Gerd/Acid Reflux
_____ Stomach Ulcers

Brain/Mental Health
_____ Anxiety
_____ Depression
_____ Seizures/Epilepsy
_____ Mental Health Disorders
_____ Neurological Disorders
_____ PTSD
_____ Other

Periodontal Health
_____ Swollen gums
_____ Loose teeth
_____ Bad breath
_____ Dry mouth
_____ Food catching between teeth
_____ Family history of Gum Disease
_____ Calcium deficiency
_____ Vitamin D deficiency

Other
_____ Glaucoma
_____ Arthritis
_____ Chronic Pain
_____ Diabetes
_____ Hepatitis
_____ Kidney Issues
_____ Malnutrition
_____ Osteoporosis
_____ Cold Sores
_____ STDs
_____ Thyroid Issues
_____ Hearing Issues
_____ Sight Issues
_____ Dementia
_____ Alzheimer's
_____ Other

Are you currently being seen or treated by a physician?_____ If yes, for what condition?_____
Are you taking any **blood thinners**? _____ If yes, what medication are you taking?_____
Are you taking any medication to treat osteoporosis? _____ If yes, what medication are you taking?_____
Do you use any type of tobacco, nicotine, or vaping products?_____ Type?_____
Amount Per Day?_____ Number of Years?_____ When did you quit?_____
How many alcoholic beverages do you have per week?_____
Do you use controlled substances, including marijuana, for medicinal or recreational reasons?_____
What substance? _____ How often is your use? _____ Was it prescribed by a doctor? _____
Have you had any type of joint replacement surgery ? _____ Date of surgery? _____
Have you had artificial heart valve surgery?_____ Date of surgery?_____
For Women: Are you: _____ Pregnant _____ Nursing _____ Using contraceptives _____ Taking hormone replacements
Is there anything else we should know about your health?_____