EASTSIDE DENTAL CLINIC

MEDICAL HISTORY

PATIENT NAME:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical Physician's Name_____ Are you under a Medical Physician's care now? ☐ YES ☐ NO
If YES; Please explain_____
Has there been any change in your health in the past year? ☐ YES ☐ NO If YES: Explain_____
Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO If YES: When? _____
Have you ever had a serious head or neck injury? ☐ YES ☐ NO
If YES; Please explain _____
Are you taking any medications, pills or drugs? ☐ YES ☐ NO
Please list all medications you are currently taking (including non-prescription medicines):_____
_____
Are you on a special diet? ☐YES ☐NO
Do you use, or have you ever used tobacco (in any form), including vaping or marijuana products? ☐YES ☐NO
If you have quit, when?_____
Do you use controlled substances? ☐YES ☐NO Do you drink Alcohol? ☐YES ☐NO If YES: How often? _____
Taking Oral Contraceptives? ☐YES ☐NO
WOMEN: Are you Pregnant? ☐YES ☐NO Have you ever taken Fosamax, Boniva, Actonel, Aredia, Zometa
Nursing? ☐YES ☐NO or any other medications containing biosphosphonates?
Trying to become Pregnant? ☐YES ☐NO ☐YES ☐NO

Are you allergic or have had an adversely bad reaction to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Metal ☐ Latex ☐ Local Anesthetic ☐ Other:_____

Do you have, or have you *ever* had, any of the following? * This condition may require pre-medication

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis (severe)
- ☐ Anemia/Bleeding Disorder
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve*
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Infective Endocarditis (serious heart infection)
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disease
- ☐ Convulsions/Seizures
- ☐ Cortisone Medicine
- ☐ Diabetes type 1 or type 2 HbA1c_____
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Disease
- ☐ Heart Murmur*
- ☐ Heart Pace Maker*
- ☐ Heart Defibrillator *
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B, C or _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Intestinal Problems
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse*
- ☐ Osteoporosis
- ☐ Pain: Jaw Joints
- ☐ Pain: Facial Muscles
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever*
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stroke or TIA
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Sleep Apnea or Use of CPAP
- ☐ Stents
- ☐ Any Disease, Drug or Transplant that has suppressed your immune system

Have you ever had any serious illness or medical condition not listed above? ☐ YES ☐ NO
If yes, please describe: _____

Do you ever require pre-medication antibiotics prior to dental treatment? ☐ YES ☐ NO
If YES: For what and when? _____ If used in the past, do you still require it? ☐ YES ☐ NO

Would you like to discuss, or do you have any concerns about, the following:

Bad Breath?	☐	Periodontal (gum tissue) Health?	☐	Crooked Teeth?	☐
Discolored Teeth/Whitening?	☐	Dental Implants?	☐	Treatment for Missing Teeth?	☐
Cosmetic Dentistry?	☐	Dental Makeovers?	☐	Dry Mouth/Inadequate Saliva Flow	☐
Frequent/Recurring Mouth Sores?	☐				

Have you been told that you have Periodontal disease? ☐ YES ☐ NO
Have you had any history of dental scaling and root planning from a Hygienist in your past? ☐ YES ☐ NO

Do you have or have you *ever* had TMJ or jaw joint issues? ☐ YES ☐ NO
If YES; what type, describe issues: _____

Help us get to know you or a family member better:

Do you have any dental fears, have anxieties when seeing the dentist or dental hygienist? ☐ YES ☐ NO

If Yes, please feel free to explain what makes you uncomfortable _____

Mark here if you would rather discuss privately with your Dentist or Hygienist: ☐ YES ☐ NO

Other Dental Concerns or Questions? ☐ YES ☐ NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patients') health. It is my responsibility to inform the dental office of any changes in medical status. I have read, completed and understand the contents on both sides of this form.

Signature of Patient (if of legal age) or of Parent/Guardian (if a minor) **Date**