MEDICAL HISTORY

Your Name ______________________Physician's Name ____________________
Emergency Contact _________________Relationship______Phone #____________
Date of last visit with a Dentist _______________
Date of last visit with Medical Doctor _____________
How did you hear about us? ____________________________
Have you had problems with previous dental treatment? YES NO
Explain: __________________
Have you ever been hospitalized or had major operation? YES NO
Explain:___________________
Have you had a serious head or neck injury/trauma?
Explain: ___________________________
Do you take blood thinners or bruise easily? YES NO
Have you ever had MRSA or an infection that did not respond to antibiotics? YES NO
Have you taken Foxamax, Boniva, Actonel, Denosumab or any other medication for bone health/osteoporosis? YES NO
Have you had joint replacement surgery? YES NO
Have you been told you need antibiotics before dental treatment? YES NO
Pain you are experiencing today (Scale):
1 2 3 4 5 6 7 8 9 10 = unbearable
Please rate your oral health today (Scale):
1 2 3 4 5 6 7 8 9 10 = very good
Please rate the importance of oral health to you (Scale):
1 2 3 4 5 6 7 8 9 10 = very good
Do you use tobacco? YES NO
Do you have a history of drug or alcohol abuse? YES NO
Do you use controlled substances? YES NO
Do you have issues opening/closing your mouth fully or chewing bagels, nuts, gum? YES NO
Do you experience dry mouth? YES NO

Are you currently taking any medications? YES NO
* If yes, please provide a list to your provider today.

Are you allergic to anything? YES NO
* If yes, please provide a list to your provider today.

Women:
Pregnant or trying to get pregnant? YES NO Due date: __________________
Taking contraceptives or other hormones? YES NO
Nursing YES NO

Are you on a special diet? YES NO Explain: ______________________________
How often do you brush your teeth? __________ How often do you floss? __________
Are you dissatisfied with the appearance of your teeth? YES NO
Do you have difficulty chewing your food? YES NO

Do you have, or have you EVER had, any of the following?

HEAD/ NEUROLOGIC
Epilepsy or Seizures? YES NO
Thyroid disease YES NO
Stroke? YES NO
Glaucoma? YES NO
Alzheimer's Disease or Dementia YES NO
Frequent headaches? YES NO
Depressions, anxiety, bipolar or other psychiatric care? YES NO

HEART/BLOOD
Heart attack/failure? YES NO
Heart murmur? YES NO
Heart Pacemaker? YES NO
Artificial Heart Valve? YES NO
Blood disorder/bleeding disorder? YES NO
High blood pressure? YES NO
High Cholesterol? YES NO
Mitral Valve Prolapse? YES NO
Chest Pain? YES NO

LUNGS
Asthma? YES NO
Emphysema/COPD? YES NO
Tuberculosis? YES NO
Sleep Apnea? YES NO
Hay fever/seasonal allergies? YES NO

URINARY/METABOLIC
Kidney problems? YES NO
History of Urinary Tract Infections with antibiotics? YES NO
Diabetes? YES NO
Excessive thirst? YES NO

LIVER
AIDS/HIV? YES NO
Hepatitis A, B or C? YES NO
Herpes (cold sores/fever blisters)? YES NO
Blood transfusion? YES NO

GI/INTESTINAL
Acid reflux (heartburn) or ulcers? YES NO
Do you gag easily? YES NO
Do you have difficulty chewing and then swallowing your food? YES NO

BONE
Arthritis? YES NO
Osteoporosis? YES NO
Pain in jaw joints? YES NO

Tumors or growths? YES NO
Cancer? YES NO Diagnosis: ______________________________
Chemotherapy? YES NO
Radiation? YES NO
Scarlet Fever? YES NO
Have you had the HPV vaccination? YES NO
Autoimmune disease or other chronic disorder? YES NO Explain: _______________

Patient signature: ____
If patient is under 18:
Parent or Legal Guardian Signature: ____
Date ______________________

TMJ, Sleep, Airway Screening

TMJ questionnaire

Have you been diagnosed with a temporomandibular jaw disorder (TMD)?   YES   NO
Do you clench or grind your jaws frequently?   YES   NO
Does your jaw make a noise that bothers you or others?   YES   NO
Does jaw pain or discomfort that affects you daily?   YES   NO
Do you have pain in the face, cheeks, jaws, joints, throat or temples?   YES   NO
Have you had jaw trauma   YES   NO
Do you have any headaches daily?   YES   NO
Do you have any headaches after waking up in the morning?   YES   NO

Sleep and Airway

Do you snore?   YES   NO
Have you been diagnosed with sleep apnea or sleep disturbance?   YES   NO
Do you experience day-time sleepiness?   YES   NO
Do you have allergies and/or asthma?   YES NO
Can you breath fully through your nose?   YES   NO
Have you had braces? YES   NO