Patient Name: ______________________________

Date of Birth: ______________________________

Medical Information

In Case of Emergency, we should notify:

Name: ____

Relationship: ____

Phone: ____

Name of Family Doctor: _________________________________

Phone: ____

1. Are you being treated for any medical condition at the present or have you been treated within the past year? Y / N
   If yes, please explain:
   ____
   ____

2. When was your last medical checkup?
   ____

3. Has there been any change in your general health in the past year? Y / N
   If yes, please explain:
   ____
   ____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Y / N
   If yes, please explain:
   ____
   ____

5. Do you have any allergies/sensitivities to food, medication or materials (eg. latex, milk, gluten)? Y / N
   If yes, please explain:
   ____
   ____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? (eg. Dental anesthetic) Y / N
   If yes, please explain:
   ____
   ____

7. Do you have or have you ever suffered from asthma? Y / N
8. Do you have or have you ever had any heart or blood pressure problems? Y / N
9. Do you have or have you ever had an artificial valve, an infection of the heart, a heart condition from birth or a heart transplant? Y / N
   If yes, please explain:
   ____
   ____

10. Have antibiotics ever been suggested prior to dentistry to prevent infective endocarditis? Y / N
11. Do you have a prosthetic or artificial joint? Y / N
    If yes, what type and when was it placed:
    ____
    ____

12. Do you have a bleeding problem or bleeding disorder? Y / N
    If yes, please explain:
    ____
    ____

13. Have you ever been hospitalized for any illness or operations? Y / N
    If yes, please explain:
    ____
    ____

14-32. Do you have or have you ever had any of the following? *(check any that apply)*

- □ chest pain, angina
- □ shortness of breath
- □ heart attack
- □ HIV, AIDS, Hepatitis C
- □ mitral valve prolapse
- □ heart murmur
- □ pacemaker
- □ lung disease
- □ chemo or radiation therapy
- □ stroke
- □ steroid therapy
- □ diabetes
- □ stomach ulcers
- □ migraines, headaches
- □ seizures (epilepsy)
- □ kidney disease
- □ cancer
- □ osteoporosis medications
- □ drug/alcohol dependency

33. Are there any conditions or diseases not listed above that you have or have had? Y / N
    If yes, please explain:
    ____
    ____

34. Do you smoke or chew tobacco products? Y /N

35-37. WOMEN ONLY- Are you:

- □ Pregnant? *Due Date*: ___________________________
- □ Nursing?
- □ Taking Birth Control Pills?

Dental Information

1. When was your last dental visit?

____

2. How often do you visit the dentist?

____

3. How often do you brush your teeth?

____

4. How often do you floss your teeth?

____

5-8 Do any of the following cause tooth discomfort
(check any that apply)
- ☐ Cold
- ☐ Hot
- ☐ Sweets
- ☐ Chewing

9. Are you having any problems that require immediate attention? Y / N
If yes, please explain:

____

____

10. Do you gums bleed when you brush your teeth? Y / N
11. Have you noticed any loose teeth? Y / N
12. Do you clench or grind your teeth? Y / N
If yes, do you wear a splint/nightguard? Y / N
13. Have you been diagnosed with sleep apnea? Y / N
14. Have you ever had orthodontic treatment? (Braces or Invisalign) Y / N
15. Do you have retainers? Y / N
16. Is there anything you would like to change about your smile? Y / N
17. Are you interested in straightening your teeth/correcting your bite? Y / N
18. Are you interested in whitening? Y / N
19. Do you have any missing teeth that you are interested in replacing? Y / N
20. Are you interested in bridges, implants, or dentures? Y / N
21. Have you been diagnosed with periodontal disease? Y / N
If so, have you had treatment for this? Y / N

22-26. Do any of the following apply to you?
(check any that apply)
- ☐ Dry Mouth
- ☐ Canker/Cold Sores
- ☐ Difficulty Opening/Closing
- ☐ Gag Reflex
- ☐ Bad Breath

27. Are you nervous during dental treatment? Y / N
28. Have you ever had any complications or issues with previous dental treatment? Y / N

____

____

29. Please list anything else not mentioned above regarding your past dental history. Y / N

____

____

If you are answering on behalf of a child, does your child:

30. Use a pacifier Y / N
31. Suck their thumb Y / N
32. Use bottle or sippy cup Y / N
33. Snore? Y / N