

Medical and Dental History Snore/SP/Facial Pain

Patient Name:

Birth Date:

Date Created:

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.

Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
Metal Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances?
Other?

Have you ever had?

Orthodontic Treatment
Oral Surgery
Periodontal Treatment
A bite plate or mouth guard
Your teeth ground or bite adjusted

Are any of your teeth sensitive to hot, cold or
Are any of your teeth sensitive to biting or chewing?
Have your parents experienced gum disease or tooth loss?
When was your last dental visit?
Do you snore?
Do you have sleep apnea?
Do you have facial pain?

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

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Emphysema
High Cholesterol
Hives or Rash
Asthma
Blood Disease
Leukemia
Liver Disease
Swelling of Limbs
Thyroid Disease
Osteoporosis
Pain in Jaw Joints
Ulcers
Cortisone Medicine
Diabetes
Drug Addiction
Herpes
High Blood Pressure
Scarlet Fever
Shingles
Fainting Spells/Dizziness
Frequent Cough
Stomach/Intestinal Disease
Stroke
Cancer
Chemotherapy
Tuberculosis
Congenital Heart Disorder
Convulsions
Hemophilia
Hepatitis A
Hepatitis B or C
Rheumatic Fever
Arthritis/Gout/ Rheumatism
Artificial Heart Valve
Artificial Joint
Irregular Heartbeat
Kidney Problems
Breathing Problems
Bruise Easily
Glaucoma
Mitral Valve Prolapse
Cold Sores/Fever Blisters
Heart Pacemaker
Heart Trouble/Disease
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Angina
Epilepsy or Seizures
Excessive Bleeding
Hypoglycemia
Sinus Trouble
Blood Transfusion
Frequent Headaches
Low Blood Pressure
Lung Disease
Heart Attack/Failure
Heart Murmur
Parathyroid Disease
Psychiatric Care

Have you ever had any serious illness not listed

Comments:

[Empty text box for comments]

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____