Medical and Dental History Form

Today's Date: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

Primary Care Physician's Name: _____

Clinic Name: _____

Medical History

Please check any of the following conditions you currently have or have had in the past:

☐ Heart Disease	☐ High Blood Pressure	☐ Anemia	☐ Rheumatic Fever
☐ Pacemaker	☐ Artificial Heart Valve	☐ Diabetes Type 1	☐ Asthma
☐ Hypoglycemia	☐ Thyroid Disease	☐ Diabetes Type 2	☐ Chronic Bronchitis
☐ Emphysema	☐ Stroke	☐ Tuberculosis	☐ HIV/AIDS
☐ Hepatitis (A, B, or C)	☐ Liver Disease	☐ Kidney Disease	☐ Renal Dialysis
☐ Lupus	☐ Multiple Sclerosis	☐ Sleep Apnea	☐ Acid Reflux/GERD
☐ Anxiety	☐ COPD	☐ Blood Clots/Thrombosis	
☐ Depression	☐ Osteoporosis	☐ Blood Disorders (e.g., Sickle Cell, Hemophilia)	
☐ Glaucoma	☐ Cold Sores/Fever Blisters	☐ Artificial Joint (hip, knee, etc.)	
☐ Cancer (Specify type) _____		☐ Autoimmune Disorder	
☐ Other (Specify): _____			

Are you currently taking any blood-thinning medications (anticoagulants or antiplatelet drugs)?

☐ Yes ☐ No

If yes, please check all that apply:

☐ Warfarin (Coumadin) ☐ Clopidogrel (Plavix) ☐ Rivaroxaban (Xarelto) ☐ Apixaban (Eliquis)

☐ Dabigatran (Pradaxa) ☐ Aspirin (regular or low-dose) ☐ Other (Please specify): _____

Do you have any history of abnormal bleeding or easy bruising?

☐ Yes ☐ No

If yes, please explain: _____

Do you currently take any medications for osteoporosis?

☐ Yes ☐ No

If yes, please check all that apply:

☐ Oral Bisphosphonates (e.g., Alendronate [Fosamax], Ibandronate [Boniva]) ☐ Denosumab (Prolia)

☐ IV Bisphosphonates (e.g., Zoledronic Acid [Reclast]) ☐ Other (Please specify): _____

History of surgeries or medical procedures: _____

Do you need to take antibiotics before dental appointments?

☐ Yes ☐ No

Are you currently pregnant?

☐ Yes ☐ No

Current Medications

☐ None

Please list all medications you are currently taking (or provide a list):

_____

_____

Allergies

☐ None

Do you have any known allergies to medications, anesthetics, or materials used in dental treatments?

☐ Yes ☐ No

If yes, please list all known allergies and reactions: _____

Other allergies: _____

Dental Health History

Please check any of the following conditions you currently have or have had in the past:

☐ Tooth Sensitivity ☐ Bleeding Gums ☐ Previous Scaling and Root Planing ☐ Previous Gum Grafting

☐Bad Breath ☐ Dry Mouth ☐ Jaw Pain ☐ Clicking or Popping of Jaw ☐ Teeth Grinding or Clenching

☐ Temporomandibular Joint Disorder (TMJ/TMD) ☐ Pain with Hot/Cold Foods ☐ Toothaches

☐ Loose Teeth ☐ Mouth Sores ☐ Oral Habits (Thumb sucking, Nail biting, etc.) ☐ Frequent Headaches

☐ Other (please specify): _____

Oral Hygiene Practices

1. **How often do you brush your teeth?**
   ☐ Once a day ☐ Twice a day ☐ More than twice a day ☐ Less than once a day
2. **What type of toothbrush do you use?**
   ☐ Manual ☐ Electric ☐ Other: _____
3. **How often do you floss?**
   ☐ Once a day ☐ Less than once a day ☐ Occasionally ☐ Rarely ☐
4. **Do you currently use any tobacco products (smoking, vaping, smokeless)?**
   ☐ Yes ☐ No
   If yes, how frequently? ☐ Daily ☐ Occasionally ☐ Quit (how long ago?) _____
5. **Do you consume sugary foods or drinks on a regular basis?**
   ☐ Yes ☐ No
   If yes, how often? ☐ Daily ☐ Occasionally ☐ Rarely

_____ _____

Patient/Parent/Legal Guardian Signature Date