

# *Designs in Dentistry*

Confidential Dental & Medical History

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Last First MI  Male  Female  
 Previous Dentist: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_

**Please circle Yes or No to each of the following questions or conditions:**

- Yes No Do you have a specific dental problem? Please describe: \_\_\_\_\_  
 Yes No Do you think you have decay or gum disease? \_\_\_\_\_  
 Yes No Do your gums bleed? Describe: \_\_\_\_\_  
 Yes No Do you use tobacco? Describe: \_\_\_\_\_  
 Yes No Do you dislike the appearance or color of your teeth? Describe \_\_\_\_\_  
 Yes No Have you ever had orthodontic treatment (tooth straightening)? \_\_\_\_\_  
 Yes No Do you ever clench or grind your teeth? Describe \_\_\_\_\_  
 Yes No Do you suffer from (experience) a dry mouth? \_\_\_\_\_  
 Yes No Do you experience clicking, popping or discomfort in your jaw joints (TMJ)? Describe \_\_\_\_\_  
 \_\_\_\_\_  
 Yes No Are you nervous or anxious about having dental treatment? \_\_\_\_\_  
 Yes No Have you ever had a bad dental experience? Describe \_\_\_\_\_  
 Yes No Are you interested in using nitrous oxide gas? \_\_\_\_\_  
 How do you take care of your teeth and gums? Describe \_\_\_\_\_

**Do you or have you ever had:**

- |   |                              |                                |                                  |
|---|------------------------------|--------------------------------|----------------------------------|
| Yes No Congenital heart conditions          | Yes No HIV positive (AIDS)   | Yes No Phen-Fen/ Redux use     | Yes No Cancer                    |
| Yes No Heart pacemaker                      | Yes No Bruise easily         | Yes No Mental health disorder  | Yes No Radiation treatments      |
| Yes No Heart surgery/stents                 | Yes No Hypoglycemia          | Yes No Alzheimer's/Dementia    | Yes No Chemotherapy              |
| Yes No Artificial heart valve               | Yes No Shortness of breath   | Yes No Drug/alcohol addiction  | Yes No Artificial joint/knee/hip |
| Yes No Stroke                               | Yes No Fainting or dizziness | Yes No Anxiety/panic disorder  | Yes No Lupus                     |
| Yes No High blood pressure                  | Yes No Allergies             | Yes No Cold sores              | Yes No Arthritis/gout            |
| Yes No Low blood pressure                   | Yes No Asthma                | Yes No Diabetes                | Yes No Rheumatism                |
| Yes No Anemia                               | Yes No Sinus conditions      | Yes No Kidney disease          | Yes No Glaucoma                  |
| Yes No Blood transfusion                    | Yes No Emphysema/COPD        | Yes No Swelling of hands/ feet | Yes No Cortisone medication      |
| Yes No Hemophilia/<br>Uncontrolled bleeding | Yes No Frequent cough        | Yes No Hepatitis               | Yes No Thyroid disease           |
|   | Yes No Tuberculosis          | Yes No Jaundice                | Yes No Para-thyroid disease      |
|   | Yes No Recent weight loss    | Yes No Epilepsy or seizures    | Yes No Osteoporosis              |

Name of Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Are you presently under the care of your physician?  Yes  No If Yes, please explain: \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No If Yes, please explain: \_\_\_\_\_

- Please list all prescription medication(s) you are taking: \_\_\_\_\_  
 Do you or have you taken bisphosphonates (i.e., Fosamax, Boniva) for cancer treatment or osteoporosis? \_\_\_\_\_  
 Do you use "recreational or street" drugs?  Yes  No  
 Are you allergic to any medications or substances?  Yes  No If Yes, please list: \_\_\_\_\_  
 Have you ever experienced a reaction to latex gloves or latex products?  Yes  No  
 Have you ever had any complications following dental treatment?  Yes  No If yes, please explain \_\_\_\_\_

Female patients:  
 Are you pregnant?  Yes  No If Yes, due date? \_\_\_\_\_  
 Are you taking birth control pills or hormone replacement therapy?  Yes  No  
 Do you have any health conditions that need further clarification?  Yes  No  
 Do you wish to speak to the dentist privately about any problem or condition?  Yes  No

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I have a change in my health, medical conditions or medications I will inform the doctor(s) and/or dental hygienist(s). I have received a copy of *The Facts About Fillings* as required by the Dental Board of California.

<b>Signature of patient, parent or guardian</b>	<b>Relationship (if other than self)</b>	<b>Date</b>
<i>Date</i>	<i>Patient Signature</i>	<i>Hygienist/Doctor Signature</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____