Howard Family Dental
Medical History

Dental History **Patient Name (please print):** ____________________

(Please check any of the following that apply to you)
- ❑ Sensitivity (hot, cold, sweets, pressure)
- ❑ Discomfort when chewing
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Bad breath/bad taste in mouth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, chipped or shifting your mouth
- ❑ Grinding or clenching teeth

What would you like to do to improve your smile?
- ❑ Whiten
- ❑ Straighten
- ❑ Close spaces
- ❑ Replace silver fillings with tooth colored fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match other teeth

Do you have or have you ever had any of the following?
❑ Dentures ❑ Partial Dentures
❑ Braces ❑ Periodontal (gum) treatments

How long has it been since your last cleaning?
❑ Less than 1 yr ❑ 1-2 yrs ❑ 3-5 yrs ❑ over 5 yrs

What is most important about your visit today? ____________________

____________________ ____________________ ____________________
Name of previous dentist Phone number City & State

Why did you leave your previous dentist? ____________________

____

Previous dental experiences: ____________________

On a scale of 1 to 10 with 10 being the highest:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Sleep History

Have you ever had a sleep study or do you currently use a CPAP? ❑Yes ❑No
Does your partner say that you snore? ❑Yes ❑No
Do you take frequent naps during the day, or often feel tired? ❑Yes ❑No
Other: ____________________

Medical History

Have you been under the care of a medical doctor during the past two years? ❑Yes ❑No
If yes, for what? ____________________

Physician's name: ____________________ Last visit to Physician: ____________________

Do you have high blood pressure? ❑Yes ❑No What is your normal blood pressure? ____________________

Emergency Contact: ____________________ **Phone Number:** ____________________

Are you allergic or have you had a reaction to the following:

		Updates:
Local Anesthetic	❑Yes ❑No	
Penicillin or other antibiotics	❑Yes ❑No	Initials ________ Date ________
Aspirin, Ibuprofen or Tylenol	❑Yes ❑No	Initials ________ Date ________
Codeine, Valium or other sedatives	❑Yes ❑No	Initials ________ Date ________
Latex or metals	❑Yes ❑No	Initials ________ Date ________

Patient Signature: ____________________ **Date:** ________
Doctor Signature: ____________________ **Date:** ________

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ❑Yes ❑No

If yes, please list: ____

____

Are you currently taking any medications, drugs or pills? ❑Yes ❑No
If yes, please list name and dosage: ____

____

____

____

Do you use tobacco? ❑Chew ❑smoke How often? __________ How long? ________________

Do you consume alcohol? ❑Yes ❑No How many beverages per week? ____________________

Do you use any mood altering drugs other than those previously listed? ❑Yes ❑No

Have you had or now have the following conditions or treatments:

Condition	Yes/No	Condition	Yes/No
AIDS	❑Yes ❑No	Heart condition	❑Yes ❑No
Alcoholism	❑Yes ❑No	Heart murmur	❑Yes ❑No
Allergies or hives	❑Yes ❑No	Heart pacemaker	❑Yes ❑No
Asthma	❑Yes ❑No	Heart surgery	❑Yes ❑No
Arthritis/Rheumatism	❑Yes ❑No	Hemophilia	❑Yes ❑No
Artificial heart valve	❑Yes ❑No	Hepatitis type _____	❑Yes ❑No
Artificial joints-type __________	❑Yes ❑No	High blood pressure	❑Yes ❑No
Bleeding/Blood disorder	❑Yes ❑No	HIV positive	❑Yes ❑No
Blood thinners/Aspirin	❑Yes ❑No	HPV	❑Yes ❑No
Bone disease or bone cancer	❑Yes ❑No	Kidney trouble	❑Yes ❑No
Bruise easily	❑Yes ❑No	Latex sensitivity	❑Yes ❑No
Cancer	❑Yes ❑No	Liver disease	❑Yes ❑No
Chemotherapy	❑Yes ❑No	Milk/Casein allergy	❑Yes ❑No
Chest pain (Angina)	❑Yes ❑No	Mitral valve prolapse	❑Yes ❑No
Chronic cough	❑Yes ❑No	Neurological disorders	❑Yes ❑No
Cold sores/Fever blisters	❑Yes ❑No	Nervous/Anxious	❑Yes ❑No
Congenital heart disease	❑Yes ❑No	Osteoporosis	❑Yes ❑No
Contact lenses	❑Yes ❑No	Psychiatric/Psychological care	❑Yes ❑No
Cortisone medicine	❑Yes ❑No	Radiation therapy	❑Yes ❑No
Diabetes: Type _______	❑Yes ❑No	Rheumatic fever	❑Yes ❑No
Drug addiction	❑Yes ❑No	Sinus trouble	❑Yes ❑No
Emphysema	❑Yes ❑No	Sleep apnea/Snoring	❑Yes ❑No
Epilepsy or seizures	❑Yes ❑No	Stroke	❑Yes ❑No
Fainting or dizzy spells	❑Yes ❑No	Thyroid problems	❑Yes ❑No
Family history of diabetes	❑Yes ❑No	Tuberculosis (T.B.)	❑ Yes ❑No
Glaucoma	❑Yes ❑No	Tumors	❑Yes ❑No
Heart attack	❑Yes ❑No	Ulcers/Reflux	❑Yes ❑No

Premedication Required: **Yes** **No** ____
Any disease, condition or problem not listed: ____

<u>Women</u>

Are you pregnant or planning a pregnancy? ❑Yes ❑No
If yes, due date: ______________________________

Are you a nursing mother? ❑Yes ❑No
Are you taking birth control pills? ❑Yes ❑No

Patient Name (Please Print) ______________________________________

Patient/Parent signature ______________________________________ **Date** ________________

Doctor Signature ______________________________________ **Date** ________________