III. Medical and Dental Health History

Legal Name: Date:

A. Medical Health Information

1. Do you have or have you had any of the following medical conditions or symptoms? ☐ No ☐ Yes:

☐ Acid Reflux	☐ Dizziness or Fainting	☐ HIV	☐ Respiratory Problems
☐ Anemia	☐ Epilepsy	☐ Intestinal Problems	☐ Rheumatic Fever
☐ Arthritis	☐ Excessive Bleeding	☐ Jaundice	☐ Rheumatism
☐ Artificial Joints/hip	☐ Glaucoma	☐ Kidney Disease	☐ Sinus Problems
☐ Asthma	☐ Growths	☐ Liver Disease	☐ Stroke
☐ Autoimmune Issue	☐ Head Injuries	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Heart Disease	☐ Mental Disorders	☐ Tuberculosis
☐ Bone/Joint Problems	☐ Heart Murmur	☐ Nervous Disorders	☐ Tumors
☐ Cancer	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Diabetes	☐ Herpes	☐ Persistent Cough	☐ Venereal or STD(s)
☐ Digestive Issue	☐ High Blood Pressure	☐ Radiation Treatment	

Other:

2. Did you receive the COVID-19 Vaccine? ☐ No ☐ Yes
   a. Which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson
   b. How many dose(s) have you received?
   c. Date of dose(s):

3. Have you tested positive for COVID-19? ☐ No ☐ Yes If yes, when?

4. Are you currently taking any medications or supplements? ☐ No ☐ Yes

Name of medication:	For:	Date started (approximately):
Name of supplement/vitamin:		

5. Are pre-medications required by your physician before receiving dental treatment?
   ☐ No ☐ Yes ☐ Unsure/Don't Know

6. Do you smoke? ☐ No ☐ Yes If yes, how much?

7. Sleep:
   a. Do you snore? ☐ No ☐ Yes
   b. Do you experience interruptions in breathing during sleep? ☐ No ☐ Yes
   c. Do you often feel tired, fatigue, or sleepy during the day? ☐ No ☐ Yes
   d. Do you have a difficult time sleeping/staying asleep? ☐ No ☐ Yes
   e. Does your family have a history of sleep apnea? ☐ No ☐ Yes
   f. Have you ever had a sleep study done before? ☐ No ☐ Yes

8. Exercise:

Do you exercise? ☐ No ☐ Yes If yes, how often?

9. Diet:

Do you consider yourself to (select all that applies):

☐ Have a healthy diet	☐ Experience weight gain
☐ Consume water regularly	☐ Consume sugary foods/drinks regularly
☐ Have a restriction on diet	☐ Have food allergies

10. Do you have a primary physician? ☐ No ☐ Yes

Name of Physician: Phone Number:

11. Please complete this section if you are female:

a. Are you pregnant? ☐ No ☐ Yes ☐ Maybe/Other:

b. Are you currently nursing? ☐ No ☐ Yes

c. Have you reached menopause? ☐ No ☐ Yes ☐ Maybe/Other:

12. Do you do any of the following Adjunctive Therapy? ☐ No ☐ Yes (select all that applies):

☐ Physical Therapy	☐ Massage Therapy
☐ Acupuncture	☐ Other:
☐ Chiropractic Treatment	☐ Other:

B. Dental Health Information

1. Do you have any of the following types of allergies? ☐ No ☐ Yes:

☐ Aspirin, Acetaminophen or Ibuprophen	☐ Local anesthetics (such as "Novocaine")
☐ Barbituates, sedatives or sleeping pills	☐ Penicillin
☐ Codeine, Demeraol or other narcotics	☐ Other Antibiotics:
☐ Fluoride	☐ Sulfa Drugs
☐ Hayfever	☐ Other:
☐ Latex or rubber dam	☐ Other:

2. Please indicate if you have, or have had any of the following conditions or experiences:

A. Head and Neck	**C. Teeth**
☐ A history of head or neck injury	☐ Difficulty opening or closing the mouth or jaw
☐ Difficulty opening or closing the mouth or jaw	☐ Clenching or grinding
☐ Frequent or severe headaches	☐ Difficulty chewing
☐ Pain to any areas of the head or neck	☐ Food gets caught between teeth
☐ Soreness around the jaw, ear or side of face	☐ Sensitivity
☐ TMJ or jaw joint problems	☐ Painful areas or twinges of pain
B. Soft Tissues	**D. Gums**
☐ A history of injury to cheeks, lips, or throat	☐ A history of injury to tissues inside of mouth
☐ Biting of lips or cheeks	☐ Bleeding gums during flossing or at other times
☐ Lumps or sores in mouth	☐ Lumps or sores on gums
☐ Slow healing sores in mouth	☐ Painful areas or twinges of pain
☐ Strong tendency to gag easily	☐ Prolonged bleeding following a tooth extraction
☐ Tenderness at the roof of mouth	☐ Sensitivity

3. Does anyone in your biological family have a history of:

☐ Cancer	☐ Drug or Alcohol Abuse	☐ High Blood Pressure
☐ Diabetes	☐ Heart Disease	☐ None

4. Which of the following applies to you? (Select all that apply)

☐ I am satisfied with the general health of my teeth and gums.	☐ Keeping my teeth for as long as possible is important to me.
☐ I am content with the way teeth look (color, etc.)	☐ Other:
☐ I brush and floss twice a day.	