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

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

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

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

5. 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

6. Exercise:
Do you exercise? ☐ No ☐ Yes If yes, how often? ______________________________

7. 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 |

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

Name of Physician ______________________________ Phone Number ______________________________

9. 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 ______________________________

10. 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 | |
| ☐ 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. | |