Complete Health Medical & Dental History Form

Although in Dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as the Gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the Dentistry you will receive. Therefore, it is important that you answer all of the pertinent questions. Thank you.

Name: _____ Date:_____ Date of Birth:_____

Insurance Information:

Are you covered by dental insurance? [ ] Yes [ ] No

Subscriber Name: _____ Relation to Patient: _____

Birth Date: _____

Address & phone *(If different from patient):* _____

_____

Insurance Company & address: _____

_____

Subscriber Employed by: _____ Business Phone: _____

ID # (listed on insurance card): _____

Whom may we thank for referring you? _____

Name and location of your current physician: _____

Parent or guardian information Person responsible for the account is a [ ] Parent [ ] Guardian

Name: _____ [ ] Male [ ] Female [ ] Married [ ] Single [ ] Other:_____

Social Security #_____ Birth date: _____ Drivers License #: _____ State:

Phone Numbers:

Home: _____ Work: _____ Cell: _____

Home street address: _____ City: _____

State: _____ Zip code: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

Personal Health

How would you rate your current health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

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Breaking ground with the Bale/Doneen Method

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Current age: _____ Weight:_____ _____ Height: _____ Ethnicity: _____

Date of your last physical exam:_____ Reason for today's visit:_____

Date of last dental care and former dentist: _____

Check (✓) if you have had problems with any of the following:

❐ Bad Breath	❐ Loose teeth or broken fillings	❐ Sensitivity when biting
❐ Grinding Teeth	❐ Sensitivity to sweets	❐ Food collection between teeth
❐ Sensitivity to hot	❐ Clicking or popping jaw	❐ Sensitivity to cold
❐ Bleeding gums	❐ Periodontal treatment	❐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Would you be interested in straighter teeth with clear aligner therapy? [ ] Yes [ ] No

Whiter teeth? [ ] Yes [ ] No Reducing snoring? [ ] Yes [ ] No

Medications: Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs.

Medications/ Supplements	*Dose (mg per pill, doses per day)*	*Start date*	*End date*

Allergies or reactions to medicines: _____

_____

Have you had any tests run at your Physician's office? If so, what were they and when were they run?

_____

_____

_____

Personal medical history

Have you ever been hospitalized for illness? [ ] Yes [ ] No

_____

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Please indicate whether you have had any of the following medical problems
(Include dates to indicate when the problem occurred.

Periodontal Disease [ ] _____
Dental infections [ ] _____
Root Canal [ ] _____
Bleeding gums [ ] _____
Heart Disease [ ] _____
Stroke [ ] _____
High Cholesterol [ ] _____
High blood Pressure [ ] _____
Pre-diabetes [ ] _____
Diabetes [ ] _____
Mini-Stroke or TIA [ ] _____
Atrial Fibrillation [ ] _____
Poor blood flow to extremities [ ] _____
Aortic Aneurysm [ ] _____
Brain aneurysm [ ] _____
Bleeding/clotting problems [ ] _____
Blood transfusions [ ] _____
Anemia [ ] _____
High red blood cell count [ ] _____
Leukemia [ ] _____
Abnormal platelet count [ ] _____
Stomach Ulcers [ ] _____
Chronic Heartburn [ ] _____
Restless legs [ ] _____
Sleep disorder [ ] _____
Cancer [ ] _____
Physical Disability [ ] _____
Mental Disability [ ] _____

Heart Arrhythmia [ ] _____
Heart Valve Problem [ ] _____
Rheumatoid Arthritis [ ] _____
Kidney disease [ ] _____
Kidney stones [ ] _____
Gallbladder stones [ ] _____
Pancreatic disease [ ] _____
Fatty liver [ ] _____
Lupus [ ] _____
Psoriasis [ ] _____
Sjögren's Syndrome [ ] _____
Autoimmune disorder [ ] _____
Gout [ ] _____
Polycystic Ovaries [ ] _____
Thyroid problems [ ] _____
Depression [ ] _____
Suicide attempts [ ] _____
Anxiety/Panic Attacks [ ] _____
Migraine Headaches [ ] _____
Thin Bones/osteoporosis [ ] _____

Post-traumatic Stress Syndrome [ ] _____
Blood Clot in Legs [ ] _____
History Hepatitis [ ] _____
Alcoholism [ ] _____
Drug Use [ ] _____
History of AIDS [ ] _____

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Surgical history

Please list all other operations with the dates when they occurred.

_____
_____
_____
_____
_____
_____

Social history

Tobacco use
Cigarettes: [ ] Never [ ] Quit: date you quit smoking _____ [ ] Current smoker(packs per day) _____

Other tobacco (check all answers that apply): [ ] Pipe [ ] Cigar [ ] Chewing tobacco [ ] e-cigarettes [ ] Marijuana
Number of years you've used this tobacco _____
Are you interested in quitting? [ ] Yes [ ] No Have you tried to quit in the past [ ] Yes [ ] No
How many times have you tried to quit? _____ What methods have you tried? _____
Are you exposed to second-hand smoke? [ ] Yes [ ] No If yes, for how long? _____

Alcohol use
Do you drink alcohol? [ ] Yes [ ] No
If yes, how many drinks do you consume per week? _____ Alcohol type _____
Does your alcohol consumption have you or others concerned? [ ] Yes [ ] No

Other concerns
Caffeine intake
Coffee _____ cups/day Tea_____ cups/day Sodas per day _____ [ ] Diet [ ] Regular
Chocolate _____ ounces per day (Circle one.) [ ] Dark [ ] Light
Do you drink energy drinks or take pills to stay awake? [ ] Yes [ ] No If yes, specify _____
Decaffeinated products? [ ] Yes [ ] No If yes, specify / how much _____

Exercise
Do you exercise regularly? [ ] Yes [ ] No What kind of exercise? _____
How long do you exercise in minutes? _____ How often? _____
If you do not exercise, why not? _____
Do you have any limitations to your ability to exercise? Please explain _____

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Socioeconomics

Occupation _____ Employer _____

Years of education/highest degree _____

Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Spouse/partner's name _____

Who lives at home with you? _____

How many children do you have (Please provide names, gender, and ages.) _____

_____

Where were you born? _____ Where did you grow up? _____

Where do you live now and for how long? _____

Oral Health

Is there a specific dental problem that you currently have? _____

How many times per day do you brush your teeth? _____ What type of toothbrush do you use? _____

Do you floss regularly? [ ] Yes [ ] No How often? _____

How often do you see your dentist? _____ Do you ever have bleeding gums? [ ] Yes [ ] No

Does your oral health concern you? [ ] Yes [ ] No If yes, why? _____

Stress

How would you classify your stress level at work? (Please check one) [ ] Low [ ] Medium [ ] High

How would you classify your stress level at home? [ ] Low [ ] Medium [ ] High

Do you often feel anxious, angry, irritated or rushed? [ ] Yes [ ] No

How do you manage your stress? _____

Do you meditate daily? [ ] Yes [ ] No If yes, how? _____

Do you perceive a lack of control of your environment? [ ] Yes [ ] No If yes, why? _____

Diet

How do you rate your diet? (Please check one) [ ] Good [ ] Fair [ ] Poor

Do you currently see a dietitian? [ ] Yes [ ] No If yes, how often? _____

Name and contact: _____

How many daily servings of the following do you have:

Whole grains _____ Fruit _____ Vegetables _____

Water _____ Nuts _____ Milk _____ what % _____

How many times a week do you consume the following items?

Eggs _____ Fish _____ Chicken/Turkey _____

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Red Meat _____ Dairy Products _____ Going out to eat _____
Butter _____ Fried Foods _____
Margarine _____ Processed foods _____

Do you have any food allergies or food sensitivities? [ ] Yes [ ] No
If yes, please explain _____
Please list ALL supplements: _____
Are you satisfied with your weight? [ ] Yes [ ] No Do you have any specific weight goals? _____

History for women

How many times have you been pregnant? _____ How many deliveries? _____ miscarriages? _____
Please list any problems you have experienced with pregnancy or delivery: _____
Do you have osteoporosis (bone loss)? [ ] Yes [ ] No osteopenia (bone thinning)? [ ] Yes [ ] No
When was the first day of your most recent period? _____ What was your age at your first period? _____
Frequency of periods _____ Length of each _____ (Check one) [ ] Regular [ ] Irregular
Menopause? [ ] Yes [ ] No
Hysterectomy? [ ] Yes [ ] No When _____ Ovaries removed? [ ] Yes [ ] No
Do you have any history of gestational diabetes? [ ] Yes [ ] No
High blood pressure or eclampsia with pregnancy? [ ] Yes [ ] No

Travel history

Any recent International Travel? [ ] Yes [ ] No
If yes, what countries and dates of stay _____
Any illnesses during or post travel? _____

Review of symptoms

Please check any current problems you have on the list below.

Constitutional: Fever/chills/sweats
[ ] Unexplained weight loss/gain
[ ] Brittle nails
[ ] Dry skin
[ ] Change in skin texture
[ ] Change in hair texture
[ ] Inability to stand heat
[ ] Inability to stand cold
[ ] Change in energy/increased weakness

[ ] Excessive thirst or urination
[ ] Swelling (Explain)
_____

Respiratory
[ ] Cough/wheeze
[ ] Difficulty breathing
[ ] Snoring
[ ] Sleep apnea/CPAP

[ ] Frequent respiratory infections

Eyes
[ ] Change in vision (Explain)
_____
[ ] Dry Eyes
[ ] Frequent irritation
[ ] History of retinal tear or hemorrhages
[ ] Double vision

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[ ] Glaucoma (Treatment?)

_____

[ ] Cataracts (Surgery?)

_____

Ear/Nose/Throat/Mouth:

[ ] Difficulty hearing/ringing in your ears
[ ] Hay fever/allergies
[ ] Bleeding gums
[ ] Dental Cavities
[ ] Painful teeth or gums
[ ] Bad breath Root
[ ] Canals Dental
[ ] implants

Cardiovascular:

[ ] Chest pain/discomfort
[ ] Palpitations (irregular heart beats)
[ ] Swelling in feet or legs
[ ] Varicose veins
[ ] Pain in extremities with exercise

Skin:

[ ] Acanthosis nigricans (dark lines around neck or under arms)
[ ] Skin tags
[ ] Flattening of nail beds
[ ] Creases in earlobes
[ ] Frequent itching of skin
[ ] Skin infections

Genitourinary:

[ ] Unusual frequency of urination
[ ] Increased urination at night that interrupts sleep
[ ] Blood in urine

Gastrointestinal:

[ ] Abdominal pain
[ ] Blood in bowel movement
[ ] Heartburn Nausea/vomiting
[ ] Diarrhea/constipation
[ ] Loss of appetite
[ ] Weight loss
[ ] Weight gain

Neurological:

[ ] Headaches
[ ] Light-headedness
[ ] Memory loss
[ ] Loss of coordination
[ ] Tingling, pain, or numbness in hands or feet

Psychiatric:

[ ] Problems with sleep
[ ] Depression
[ ] Panic attacks
[ ] Mania
[ ] Anxiety
[ ] Anger issues
[ ] Short temper or impatience
[ ] Unusual feeling of doom
[ ] Suicidal thoughts
[ ] Hopelessness and constant worry

Blood/Lymphatic:

[ ] Easy bruising/bleeding
[ ] Unexplained lumps
[ ] Unusual bleeding
[ ] Unusually pale
[ ] History of blood clots
[ ] History of low platelet counts
[ ] History of high platelet counts
[ ] History of low white blood cell counts
[ ] History of anemia

Muscle/Skeletal: Chronic

[ ] joint problem
[ ] Back problems

[ ] Neck problems
[ ] Spine problems
[ ] Muscle injuries
[ ] Arthritis
[ ] History of bone fractures
[ ] History of torn or ruptured tendons
[ ] Paralysis of any muscles
[ ] Unusual muscle weakness
[ ] Any muscle side effects from statins

Any other symptoms? If so, please list them: _____

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Family history

Please indicate with a check mark any family members who have had any of the following medical conditions:

Medical condition	Mom	Dad	Sister	Brother	Daughter	Son	Mom's mom	Mom's dad	Dad's mom	Dad's Dad	Mom's sister	Mom's brother	Dad's sister	Dad's brother
Heart attack														
Stroke														
Diabetes-Type 2 (adult onset)														
Alcoholism														
Anemia														
Aortic aneurysm														
Alzheimer's														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding problems														
Carotid artery disease														
Cancer														
Depression														
Diabetes-Type 1 (childhood onset)														
Other genetic disease														
High cholesterol (hyperlipidemia)														
High blood pressure (hypertension)														
Immunosuppressive disorders														
Kidney disease														
Osteoporosis														
Peripheral vascular disease														
Epilepsy (seizure disorder)														
Substance abuse														
Thyroid disorder														
Smoking														
Sleep apnea														
Polycystic ovary Disease														
Coronary bypass														
Coronary stents														
Mini strokes														
Gum Disease														
Bad teeth														

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient(Parent or Guardian) Date

_____ _____

Signature of Dentist Date