UNIVERSITY OAKS DENTAL

Medical Health History

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Do you have or have you had any of the following? (Please check any that apply)

Heart problems:

- ☐ Chest pain/shortness of breath
- ☐ Blood pressure problem
- ☐ Heart murmur
- ☐ Artificial heart valve
  Year: _____
- ☐ Rheumatic fever
- ☐ Pacemaker
- ☐ Congenital heart disease
- ☐ Heart attack
- ☐ Heart valve problem

Blood problems:

- ☐ Easy bruising
- ☐ Anemia
- ☐ Blood transfusion
  Year: _____
- ☐ Abnormal bleeding

Allergies

- ☐ Hay fever/
- ☐ Sinus problems
- ☐ Skin rashes
- ☐ Food allergies

Intestinal problems:

- ☐ Ulcers
- ☐ Weight gain or loss
- ☐ Special diet
- ☐ Kidney or bladder problems

Bone or joint problems

- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement
  (total hip, pins, implants)
  Year: _____

Lung problems :

- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Chronic bronchitis

Other:

- ☐ Fainting, dizziness, seizures or epilepsy
- ☐ Stroke(s) year:_____
- ☐ Frequent or severe headaches
- ☐ Thyroid problems
- ☐ Premedication required by physician
- ☐ Cancer/tumor
  Type: _____ year: _____
- ☐ Radiation/chemotherapy
  Year: _____
- ☐ Do you drink alcohol?
  If so how much: _____
- ☐ Do you smoke/vape?
  If so how much: _____
- ☐ Hepatitis, jaundice, liver trouble
- ☐ Herpes or other STD
- ☐ HIV positive/AIDS
- ☐ Glaucoma

Are you allergic, or have you reacted adversely, to any of the following?

- ☐ Local anesthetic
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Aspirin, Acetaminophen, Ibuprofen
- ☐ Codeine, Demerol or other narcotics
- ☐ Reaction to metal or latex

During the last 12 months, have you taken any of the following?

- ☐ Anticoagulants (Coumadin)
- ☐ High blood pressure medication
- ☐ Tranquilizers
- ☐ Insulin, Orinase or similar drugs
- ☐ Digitalis or drugs for heart trouble
- ☐ Nitroglycerin
- ☐ Cortisone

Women

- ☐ Taking contraceptives or hormones
- ☐ Pregnant. delivery date: _____
- ☐ Nursing
- ☐ Menopause

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

Yes: _____

Dental History

- ☐ Problems with previous dental treatment
  _____
- ☐ Gag easily
- ☐ Food that catches between the teeth
- ☐ Anxiety/fear of dental treatment
- ☐ Bleeding/swollen gums
- ☐ Jaw pain/popping/clicking/difficulty opening your mouth
- ☐ Sensitivity/pain
  - Hot
  - Cold
  - Sweet
  - chewing
- ☐ Bad breath
- ☐ Cold sores/fever blisters
- ☐ Loose or missing teeth
- ☐ Been told that you snore
- ☐ Trauma to the head/jaws
- ☐ Clenching/grinding
- ☐ Dry mouth

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

Is there anything you want to discuss privately with the Dentist? YES / NO

Please list any medication you take:
_____
_____
_____

What do you like about your smile?
_____

What would you like to improve on in your smile or oral health?
_____

If you could have the perfect smile, what would it look like?
_____

Is there anything getting between you and getting this done?
_____

Is there anything that might stop you from becoming a permanent part of our patient family?
_____

_____ _____ _____

Patient's signature | Dentist Signatrue | Date