UNIVERSITY Dental Group PL
Cosmetic • Restorative • Preventive

# Patient Medical History

Patient's Full Name *

Date of Birth *

Today's Date *

## Dental History

When was your last dental exam?

When were your last dental X-rays taken?

How often do you brush?

How often do you floss?

## Hospitalizations & Surgeries

Reason

Date

Reason

Date

Reason

Date

## Current Medications

Name

Name

Name

Name

Name

Name

Name

Name

Name

Name

Name

Name

Are you taking any antacids? ☐ Yes ☐ No If yes, how often?

Are you taking Tagamet (cimetidine)? ☐ Yes ☐ No If yes, how often?

Are you taking any herbal supplements/medications? ☐ Yes ☐ No

If yes, which ones?

Are you a smoker? ☐ Yes ☐ No If yes, how much per day?

**Allergies**

- ☐ Acrylics
- ☐ Anaphalaxis
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other

List Other Known Allergies:

**Cardiovascular**

- ☐ Abnormal Heart Condition
- ☐ Artificial Heart Valve
- ☐ Coronary Artery Disease
- ☐ Chest Pain or Angina
- ☐ Congenital Heart Defect
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Tachycardia

**Oral**

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Gums
- ☐ Broken Fillings
- ☐ Fever Blisters/Cold Sores
- ☐ Dry Mouth
- ☐ Loose Teeth
- ☐ Mouth Sores
- ☐ Jaw Problems (TMJ)
- ☐ Clicking
- ☐ Pain
- ☐ Difficulty Swallowing
- ☐ Difficulty Chewing
- ☐ Soreness of Jaw/Facial Muscles
- ☐ Orthodontics/Invisalign
- ☐ Periodontal Disease/Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Pressure
- ☐ Sensitivity to Sweets
- ☐ Swollen Gums
- ☐ Teeth Clenching
- ☐ Teeth Grinding
- ☐ Tooth Pain
- ☐ Wisdom Teeth Extraction
- ☐ Currently Use Removable Dentures

**Gastrointestinal**

- ☐ Acid Reflux
- ☐ Colitis
- ☐ GERD
- ☐ Soft or Special Diet
- ☐ Ulcers

**Neurological**

- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Dizziness
- ☐ Fainting
- ☐ Memory Loss
- ☐ Multiple Sclerosis (MS)
- ☐ Muscle Weakness
- ☐ Seizures
- ☐ Stroke
- ☐ Tingling/Numbness
- ☐ Parkinson's Disease
- ☐ Tremors
- ☐ Trigeminal Neuralgia

**Musculoskeletal**

- ☐ Artificial Bones/Joints
- ☐ Arthritis
- ☐ Back Pain
- ☐ Fibromyalgia
- ☑ **Joint Pain**

**General**

- ☐ Cancer
- ☐ Cosmetic Surgery
- ☐ Fatigue/Tired
- ☐ General Weakness
- ☐ Headaches
- ☐ HIV/AIDS
- ☐ Liver Problems
- ☐ Recent Trauma/Injury
- ☐ Rheumatic Fever
- ☐ Radiation Treatment
- ☐ Shingles
- ☐ Venereal Disease
- ☐ Recent Weight Change

# Medical History Continued

Please check the box if you have a history related to any of the following:

**Eyes, Ears, Nose & Throat**

- ☐ Change in Hearing
- ☐ Change in Vision
- ☐ Difficulty Breathing
- ☐ Ear Pain
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Nasal Obstruction
- ☐ Nose Bleeding
- ☐ Sinus Problems
- ☐ Tonsillectomy
- ☐ Tinnitus

**Endocrine**

- ☐ Diabetes
- ☐ Gout
- ☐ Kidney Problems/Dialysis
- ☐ Hormonal Change
- ☐ Thyroid Problems

**Genitourinary**

- ☐ Frequent Urination
- ☐ Nocturia

**Respiratory**

- ☐ Asthma
- ☐ Bronchitis
- ☐ Breathing Problems
- ☐ Chest Pressure
- ☐ Congestion
- ☐ Dyspnea (shortness of breath)
- ☐ Emphysema
- ☐ Orthopnea
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Tuberculosis
- ☐ Mouth Breather

**Hematological**

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Blood Transfusions
- ☐ Hemophilia
- ☐ Hepatitis A,B, or C

**Psychiatric**

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Eating Disorders
- ☐ Excessive Stress
- ☐ Memory Problems
- ☐ Irritable

**Sleep**

- ☐ Daytime Sleepiness
- ☐ Morning Headaches
- ☐ Snore
- ☐ Obstructive Sleep Apnea
- ☐ Use a CPAP

**Social History**

- ☐ Cigarettes/Cigars
- ☐ Smokeless tobacco
- ☐ Consume alcoholic beverages
- ☐ Recreational drugs

**Females Only**

- ☐ Currently Taking Birth Control Pills
- ☐ Possibility of Pregnancy
- ☐ Currently Breastfeeding
- ☐ Planning to get pregnant in the next 6 months

**Current Weight**

**Current Height**

**What is your normal Blood Pressure?**

S D

**Do you have any conditions that require you to premedicate with antibiotics for dental procedures?**

**Is there any disease or medical condition that has not been listed? If yes, then please describe below**

**Physician Name**

**Physician Phone**

**Pharmacy Name**

**Pharmacy Phone**

**Is there anything you would like to see changed about your smile?**

**Do you have any other dental complaints?**

Are you interested in receiving information about any of the services below? (please check all that apply)

- ☐ Bleaching (teeth whitening)
- ☐ Traditional Orthodontics/Braces
- ☐ Invisalign/Clear Braces
- ☐ Dental Implants
- ☐ Porcelain Veneers/Lumineers
- ☐ Sedation Dentistry
- ☐ Sleep Apnea/Snoring Appliances