Advanced Dental
Personalized & Comfortable

Medical & Dental History

Obtaining a complete medical history is important, as it affects your dental and overall health, wellness and longevity. It could also make a difference in what we determine to be the best course of treatment for your personal situation. Thank you for taking the time to carefully complete this form so that we can provide you with optimal and comprehensive/complete care.

Patient Name: _____ DOB: _____

Heart Concerns*	( ) Yes	( ) No
Heart Disease/Attack*	( ) Yes	( ) No
Heart Murmur	( ) Yes	( ) No
High Blood Pressure*	( ) Yes	( ) No
Low Blood Pressure	( ) Yes	( ) No
Mitral Valve Prolapse	( ) Yes	( ) No
Artificial Heart Valve	( ) Yes	( ) No
Pacemaker	( ) Yes	( ) No
Rheumatic Fever	( ) Yes	( ) No
Stroke*	( ) Yes	( ) No
PRE-MEDICATION Required?	( ) Yes	( ) No

Periodontal (gum) disease & dental infections may increase your risk for heart attack, stroke and other serious cardiac concerns.

Anemia	( ) Yes	( ) No
Bleeding Disorder	( ) Yes	( ) No
Coumadin/Blood Thinners	( ) Yes	( ) No
Sickle Cell Disease	( ) Yes	( ) No
Liver Disease/Jaundice	( ) Yes	( ) No
Hepatitis	( ) Yes	( ) No
Type I/II Diabetes*	( ) Yes	( ) No

Last HbA1c Date & Score: _____

Studies show a strong correlation between diabetes and periodontal disease. It is important that both diseases are managed & well controlled. Warning signs of diabetes are frequent restroom trips, being thirsty all the time and always feeling hungry.

History or Current Smoker/Tobacco	( ) Yes	( ) No
Recreational/Street Drugs	( ) Yes	( ) No
Have you ever worn braces?	( ) Yes	( ) No

Do you regularly use the following?

Toothbrush	( ) Yes	( ) No
Dental Floss	( ) Yes	( ) No
Mouth Rinse	( ) Yes	( ) No
Water Pik or Irrigator	( ) Yes	( ) No

Asthma	( ) Yes	( ) No
Sinus Problems	( ) Yes	( ) No
Seasonal Allergies	( ) Yes	( ) No
Mouth Breather	( ) Yes	( ) No
Snoring	( ) Yes	( ) No
Sleep Apnea*	( ) Yes	( ) No

If so, do you wear a CPAP?_____

Cancer*	( ) Yes	( ) No
Radiation/Chemotherapy	( ) Yes	( ) No
Artificial Joints	( ) Yes	( ) No
Kidney Disease	( ) Yes	( ) No
Epilepsy/Seizures	( ) Yes	( ) No
AIDS/HIV	( ) Yes	( ) No
HPV	( ) Yes	( ) No
Neurological Disorders	( ) Yes	( ) No
Thyroid Disorder	( ) Yes	( ) No

Any Special Accommodations Needed? _____

Psychiatric/Psychological	( ) Yes	( ) No
Headaches	( ) Yes	( ) No
Dizziness	( ) Yes	( ) No
Daytime Sleepiness	( ) Yes	( ) No
Weight Gain or Trouble Losing Weight	( ) Yes	( ) No
Jaw Clicking/Popping	( ) Yes	( ) No
Limited Opening of Jaw	( ) Yes	( ) No
Clenching/Grinding	( ) Yes	( ) No
Difficulty Swallowing	( ) Yes	( ) No
Gagging/Gasping	( ) Yes	( ) No
Breath Odor	( ) Yes	( ) No
Loose/Sensitive Teeth	( ) Yes	( ) No

For Women:

Currently Pregnant	( ) Yes	( ) No
Currently Nursing	( ) Yes	( ) No

Pregnant women with periodontal disease may have up to 7 times increased risk for a pre-term, low birth weight baby.

How often do you brush? _____

Bleeding Gums	( ) Yes	( ) No

Allergies to medication(s), latex, or any substance?	( ) Yes	( ) No	List: _____
Do you take any medication(s) or prescriptions?	( ) Yes	( ) No	List: _____
Do you use any supplements or herbs?	( ) Yes	( ) No	List: _____

Feel free to use the back of this page if you need more room to list any of your allergies, medications or supplements

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~ADVANCED DENTAL IS COMMITTED TO TOTAL BODY HEALTH, WELLNESS & LONGEVITY~

*Please provide any **relevant family history** for any *starred item* above: _____

_____

Name of Physician: _____ Phone #: _____

Patient Signature: _____ Date: _____