WHITE OAKS DENTAL

Medical and Dental Health History

Patient Name: _____

☐ Male ☐ Female ☐ Transgender

Pronoun: He/him/his, She/her/hers, They/them/their Preferred Name:_____

New Patients:

Name and address of Previous Dentist: _____

Date of Last Dental Exam: _____ Date of Last Dental Cleaning: _____ Date of Last X-Rays: _____

Why have you come to see us today (e.g. pain, checkup, etc.)? _____

_____

Name of Family Physician: _____Phone: _____

Dental Health:

Yes	No	
☐	☐	Do you brush your teeth? How often? _____
☐	☐	Do you floss your teeth? How often? _____
☐	☐	Are you having any pain or discomfort at this time?
☐	☐	Does food or floss catch between your teeth?
☐	☐	Do your gums bleed while brushing and flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Have you ever experienced any of the following problems with your jaw? (Circle all that apply): clicking pain difficulty in opening and closing difficulty in chewing
☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	Do you clench or grind your teeth? If yes, when? _____
☐	☐	Have you ever had any orthodontic treatment? If so, do you wear a retainer? _____
☐	☐	Have you ever had facial surgery? If so, when and what area of your face? _____
☐	☐	Have you ever had any type of trauma to your mouth, jaw or face? If so, describe: _____ _____
☐	☐	Do you wear dentures or partials? If so, date of placement:
☐	☐	Do you have any concerns about bad breath odor?
☐	☐	Are you pleased with the appearance of your teeth when you smile?
☐	☐	Are you pleased with the color of your teeth?
☐	☐	Is there any dental treatment you are not happy with?
☐	☐	Are you nervous about dental treatment?
☐	☐	Is your home water supply fluoridated?
☐	☐	Do you drink bottled or filtered water? If so, how often? (Circle one) Daily Weekly Occasionally
☐	☐	Is your mouth dry?

Medical Health:

Are you allergic or have you reacted adversely to any of the following (check all that apply):

_____ Aspirin	_____ Ibuprofen	_____ Codeine
_____ Sulfa Drugs, Sulfites, Sulfides	_____ Nitrous Oxide	_____ Acetaminophen/Tylenol
_____ Penicillin	_____ Barbiturates	_____ Erythromycin
_____ Tetracycline	_____ Latex, Metals, Plastic	_____ Other antibiotics
_____ Local Anesthesia (Novocaine)		

(Continued on back)

Please list any other allergies to include medications you are allergic to: _____

_____

Check any of the following that you *have had* or *have* at the present:

_____ Osteoporosis
_____ Heart disease or heart attack
_____ High or Low Blood pressure
_____ Heart murmur/mitral valve prolapse
_____ Rheumatic fever
_____ Heart pacemaker
_____ Heart surgery
_____ Stroke
_____ Kidney disease
_____ History of drug addiction/alcoholism
_____ Arthritis
_____ Shingles
_____ Bleeding disorders
_____ Hay fever
_____ Ulcers
_____ Jaundice
_____ Herpes
_____ Cancer/chemotherapy, radiation
_____ Blood transfusion
_____ Fainting
_____ Allergies (including food)
_____ Hard of hearing
_____ Cholesterol

_____ Bisphosphonate therapy (e.g. Boniva, Fosamax, Actonel)
_____ Asthma
_____ Diabetes
_____ Thyroid issues
_____ Hepatitis A, B, C
_____ Hemophilia
_____ Epilepsy or seizures
_____ Psychiatric treatment
_____ Implants/artificial joints Date of Surgery: _____
_____ Anemia
_____ AIDS or HIV+
_____ Congenital heart lesions
_____ Tuberculosis or lung disease
_____ Sinus issues
_____ Liver disease
_____ Infectious mononucleosis (mono)
_____ Tumor or malignancy
_____ Radiation treatment
_____ Anaphylaxis
_____ Sickle cell disease/traits
_____ Headaches
_____ Glaucoma
_____ Cold sores or Fever Blisters

Other _____

Major surgeries (type and year): _____
_____

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements.

Name of medication	Dosage	Times taken	When (daily, as needed)

Yes	No	
☐	☐	Have you been hospitalized during the past two years?
☐	☐	Have you been asked by your medical doctor to premedicate before any dental treatment?
☐	☐	Do you have any disease, condition or problem not listed?
☐	☐	Do you smoke or use chewing tobacco? How often: _____
☐	☐	Are you pregnant or could be pregnant? If yes, due date: _____

This space below is for you to tell us other information you believe we should take into account when planning your treatment.

_____
_____

Authorization: I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signature of Patient/Responsible Party _____ Date: _____