Artistic Dentistry Medical & Dental History

Patient Name: _____ **Date of Birth:** _____

Primary Care Physician Name and Phone Number: _____

Do you have any **allergies** to the medications / materials listed:

☐ YES	☐ NO	Anesthetic		☐ YES	☐ NO	Ibuprofen	
☐ YES	☐ NO	Aspirin		☐ YES	☐ NO	Latex	
☐ YES	☐ NO	Clindamycin		☐ YES	☐ NO	Morphine	
☐ YES	☐ NO	Codeine		☐ YES	☐ NO	Penicillin	

List any other **Allergies**: _____

What Medical Conditions do you have **now**, or have you had in the **past**?

☐ YES	☐ NO	**Alcohol Abuse**		☐ YES	☐ NO	**Herpes/Fever Blisters**	
☐ YES	☐ NO	**Anemia**		☐ YES	☐ NO	**High Blood Pressure**	
☐ YES	☐ NO	**Arthritis/Pain in Joints**		☐ YES	☐ NO	**HIV / AIDS**	
☐ YES	☐ NO	**Arificial Joints/Implants**		☐ YES	☐ NO	**Immunosuppression**	
☐ YES	☐ NO	**Asthma/Breathing problems**		☐ YES	☐ NO	**Kidney Problems**	
☐ YES	☐ NO	**Cancer/Chemo/Radiation**		☐ YES	☐ NO	**Low Blood Pressure**	
☐ YES	☐ NO	**COPD**		☐ YES	☐ NO	**Mental Health Discorders**	
☐ YES	☐ NO	**Diabetes**		☐ YES	☐ NO	**Osteoporosis**	
☐ YES	☐ NO	**Dizziness/Fainting**		☐ YES	☐ NO	**Pacemaker**	
☐ YES	☐ NO	**Drug/Substance Abuse**		☐ YES	☐ NO	**Persistent Swollen Glands-Neck**	
☐ YES	☐ NO	**Dry Mouth**		☐ YES	☐ NO	**Pregnant or Nursing**	
☐ YES	☐ NO	**Emphysema/Bronchitis/Persistent Cough**		☐ YES	☐ NO	**Pre Medication Needed for Dental Visit**	
☐ YES	☐ NO	**Epilepsy/Seizures**		☐ YES	☐ NO	**Recurrent Infections**	
☐ YES	☐ NO	**Frequent/Severe Headaches**		☐ YES	☐ NO	**Sinus Trouble**	
☐ YES	☐ NO	**Gastritis / Ulcers**		☐ YES	☐ NO	**Sores/Ulcers in Mouth**	
☐ YES	☐ NO	**Glaucoma**		☐ YES	☐ NO	**Stroke**	
☐ YES	☐ NO	**Heart Condition**		☐ YES	☐ NO	**Thyroid Problems**	
☐ YES	☐ NO	**Hemophilia/Abnormal Bleeding/Blood Disease**		☐ YES	☐ NO	**Tuberculosis**	
☐ YES	☐ NO	**Hepatitis/Jaundis/Liver Disease**		☐ YES	☐ NO	Any Other Conditions, if yes list below	

_____

Please List **ALL Medications AND Supplements** you currently take:

_____ _____

_____ _____

_____ _____

Have you ever taken Bone Density Medication? ☐ YES ☐ NO Name _____ # Years Taken _____

Do you Smoke, Vape, or Use Tobacco? ☐ YES ☐ NO Type _____ Frequency of Use _____

List Any **Surgeries** or **Serious Illnesses** within the last 3 years: _____

_____

Do you Wear dentures or Partials? ☐ YES ☐ NO UPPER - How Long _____ LOWER - How Long _____

Have you had Regular Dental Care? ☐ YES ☐ NO When was your last visit to a Dentist? _____

Do you have Dental Pain/Problems now? ☐ YES ☐ NO Describe _____

I have responded honestly to the above information and to the best of my ability. I understand providing incorrect information can be dangerous to my health. I will notify this office of any changes in my health or medications.

PATIENT SIGNATURE **DATE**