Mountain View Dental pa

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Medical & Dental History Form

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Have you ever had complications following dental treatment?

Are you currently under the care of a physician due to a specific condition?

Have you been hospitalized within the last 5 years due to a surgery or illness?

Do you use tobacco (smoking or chewing)?

Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

Please indicate if you have experienced any of the follwing:

- [ ] ADHD/ADD
- [ ] AIDS
- [ ] Allergy-Aspirin
- [ ] Allergy-Codeine
- [ ] Allergy-Erythro
- [ ] Allergy-Hay Fever
- [ ] Allergy-Latex
- [ ] Allergy-Metals
- [ ] Allergy-Other
- [ ] Allergy-Penicillin
- [ ] Allergy-Sulfa
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Artificial Prosth
- [ ] Asthma
- [ ] Autism
- [ ] Blood Disease
- [ ] Blood Pressure-High
- [ ] Blood Pressure-Low
- [ ] Cancer
- [ ] Diabetes
- [ ] DO NOT RECLINE
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart MVP
- [ ] Hepatitis
- [ ] HIV-Pos
- [ ] Immunosupressed
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] MEDS-Anticoag
- [ ] MEDS-BP
- [ ] MEDS-Dilantin
- [ ] MEDS-Other
- [ ] NO EPI
- [ ] No Exts. Bisphosphon
- [ ] Other patient note
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] PREMED-Amox
- [ ] PREMED-Clinda
- [ ] PREMED-Erythro
- [ ] PREMED-Keflex
- [ ] PREMED-Other
- [ ] Psychiatric Care
- [ ] Radiation Tx
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] STDs
- [ ] Stomach Problems
- [ ] Stroke
- [ ] TB
- [ ] Thyroid Disorder
- [ ] Tumors
- [ ] Ulcers
- [ ] Xerostomia/Dry Mouth

If you are pregnant: When is your due date _____

If any of the prior condition boxes were checked, please explain.

Please list all medications and supplements you are currently taking.

Do you have any artificial joints, staples, plates or screws?

Do you have any artificial heart valves or heart stents?

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail. This box will serve as my electronic signature.**

Relationship to Patient:

_____

_____

_____

Response Date: ____/____/_____