# CAHOON FAMILY DENTAL

Medical History Form

**Patient Information: The medical information requested below is vital in helping us provide our best care to you for both your dental needs and overall health. Our team may ask additional questions regarding your health history based on your responses. This information is for our records and will remain confidential.**

Today's Date___________________________________

Patient Name_______________________________________________________________________________________________

## PATIENT DENTAL HISTORY

Reason for your visit today____________________________________

Do you have any pain or discomfort?........................ ☐ Yes ☐ No

Do your gums bleed?................................................ ☐ Yes ☐ No

Have you ever had surgery on your gums?................ ☐ Yes ☐ No

Have you ever worn braces?..................................... ☐ Yes ☐ No

Do you clench or grind your teeth?............................ ☐ Yes ☐ No

Do you floss?............................................................. ☐ Yes ☐ No

How often?________________________________________

Date of last cleaning and exam_____________________________________

Are your teeth sensitive to hot or cold liquids?..................... ☐ Yes ☐ No

Are your teeth sensitive to sweet or sour liquids/foods?...... ☐ Yes ☐ No

Do you have any sores or lumps in or around your mouth?.. ☐ Yes ☐ No

Are you unhappy with your smile?...................................... ☐ Yes ☐ No

Do you bite your lips or cheeks frequently........................... ☐ Yes ☐ No

Have you ever had trauma to your face or mouth?............ ☐ Yes ☐ No

How many times per day do you brush your teeth?___________________

## PATIENT MEDICAL HISTORY

Do you, or have you had, any of the following?

| YES | NO | CONDITION | YES | NO | CONDITION | YES | NO | CONDITION |
|---|---|---|---|---|---|---|---|---|
| | | Abnormal Bleeding From a Cut | | | Excessive Bleeding | | | Mitral Valve Prolapse |
| | | AIDS/HIV Positive | | | Excessive Thirst | | | Pain in Jaw Joints |
| | | Alzheimer's Disease | | | Fainting Spells/Dizziness | | | Parathyroid Disease |
| | | Anaphylaxis | | | Frequent Cough | | | Psychiatric Care |
| | | Anemia | | | Frequent Diarrhea | | | Radiation Treatments |
| | | Angina | | | Frequent Headaches | | | Recent Weight Loss |
| | | Arthritis/Gout | | | Genital Herpes | | | Recurrent Illnesses |
| | | Artificial Heart Valve | | | Glaucoma | | | Renal Dialysis |
| | | Artificial Joint | | | Hay Fever | | | Rheumatic Fever |
| | | Asthma | | | Heart Attack/Failure | | | Rheumatism |
| | | Biopsies | | | Heart Murmur | | | Scarlet Fever |
| | | Blood Disease | | | Heart Pace Maker | | | Shingles |
| | | Blood Transfusion | | | Heart Stent | | | Sickle Cell Disease |
| | | Breathing Problem | | | Heart Trouble/Disease | | | Sinus Trouble |
| | | Bruise Easily | | | Hemophilia | | | Slow-Healing Mouth Sores |
| | | Cancer | | | Hepatitis A | | | Sore/Enlarged Lymph Nodes |
| | | Chemotherapy | | | Hepatitis B or C | | | Spina Bifida |
| | | Chest Pains | | | Herpes | | | Stomach/Intestinal Disease |
| | | Cold Sores/Fever Blisters | | | High Blood Pressure | | | Stroke |
| | | Congenital Heart Disorder | | | Hives or Rash | | | Swelling of Limbs |
| | | Convulsions | | | Hypoglycemia | | | Thyroid Disease |
| | | Cortisone Medicine | | | Irregular Heartbeat | | | Tonsillitis |
| | | Diabetes | | | Kidney Problems | | | Tuberculosis |
| | | Drug Addiction | | | Leukemia | | | Tumors or Growths |
| | | Easily Winded | | | Liver Disease | | | Ulcers |
| | | Emphysema | | | Low Blood Pressure | | | Venereal Disease |
| | | Epilepsy or Seizures | | | Lung Disease | | | Yellow Jaundice |

Have you ever had any serious illness or condition not listed above? ☐ Yes ☐ No

If yes, please explain___________________________________________________________________________

Are you required to pre-medicate prior to dental treatment?........................................................................................................ ☐ Yes ☐ No

Are you currently under a physician's care?........................................................................................................................... ☐ Yes ☐ No

If yes, please explain_______________________________________________________________________________________

Please list all the names and phone numbers of the physicians who are currently providing you care.

1. ____________________________________________ 3. ____________________________________________

2. ____________________________________________ 4. ____________________________________________

Please list any medications you are currently taking, with the dosages.

1. ____________________________________________ 3. ____________________________________________

2. ____________________________________________ 4. ____________________________________________

Please list any dietary or herbal supplements you are taking, and for what purpose.

1. __________________________________________ 3. ____________________________________________

2. __________________________________________ 4. ____________________________________________

Have you been hospitalized or had a major operation in the last 5 years?........................................................................ ☐ Yes ☐ No

If yes, please explain_______________________________________________________________________________________

Have you ever had a serious head or neck injury?................................................................................................................... ☐ Yes ☐ No

If yes, please explain_______________________________________________________________________________________

Are you on a special diet?........................................................................................................................................................ ☐ Yes ☐ No

If yes, please explain_______________________________________________________________________________________

Do you have a history of high blood pressure?........................................................................................................................ ☐ Yes ☐ No

If yes, what is a typical reading S_______/D_______

Do you take or have you taken Phen-Fen or Redux?.................................................................................................................. ☐ Yes ☐ No

Have you ever used Biosphoshonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)?...................................................... ☐ Yes ☐ No

If yes, when did the treatment begin and end___________________________________________________________________

Are you currently taking any of the following medications:

Antacids.................................................................................................................................................... ☐ Yes ☐ No

Dilantin or Tegretol.................................................................................................................................. ☐ Yes ☐ No

Barbituates ............................................................................................................................................... ☐ Yes ☐ No

St. John's Wort or Kava-Kava.................................................................................................................... ☐ Yes ☐ No

Tagamet (Cimetidine) or Prilosec (Omeprazole)....................................................................................... ☐ Yes ☐ No

Cardizem (Diltiazem) or Calan, Isoptin (Verapamil)................................................................................. ☐ Yes ☐ No

Serzone (Nefazodone)............................................................................................................................... ☐ Yes ☐ No

Diflucan (Fluconazole) or Sporonox (Itraconazole)................................................................................... ☐ Yes ☐ No

Biaxin (Clarithromycin) ............................................................................................................................. ☐ Yes ☐ No

Do you regularly consume grapefruit juice, grapefruits or grapefruit extract?........ ☐ Yes ☐ No

Do you use tobacco?........ ☐ Yes ☐ No

If yes, what type and how frequently____________________

Do you use any controlled substances?........ ☐ Yes ☐ No

Are you allergic or have you had a reaction to any of the following:

Local anesthetics........ ☐ Yes ☐ No

Penicillin or other antibiotics........ ☐ Yes ☐ No

Aspirin........ ☐ Yes ☐ No

Codeine, Valium or other sedatives........ ☐ Yes ☐ No

Acrylic........ ☐ Yes ☐ No

Latex........ ☐ Yes ☐ No

Metals........ ☐ Yes ☐ No

If Others, please list____________________

**For Women Only:**

Are you pregnant or think you could be pregnant?........ ☐ Yes ☐ No

If not pregnant, are you planning a pregnancy in the near future?........ ☐ Yes ☐ No

Are you currently using oral contraceptives?........ ☐ Yes ☐ No

Are you a nursing mother?........ ☐ Yes ☐ No

*I certify that I have read and understand the above information. To the best of my knowledge, the questions on this form have been accurately answered. I understand that the above information is necessary to provide dental care in a safe and efficient manner and that providing incorrect information can be dangerous to my health. It is my responsibility to inform Cahoon Family Dental of any changes in medical status. Should additional information be needed, I give permission for my respective health care provider or agency to release such information to Cahoon Family Dental.*

| ____________________ | ____________________ | __________ |
|---|---|---|
| (Please Print) Name of Patient | Signature of Patient/Parent or Guardian | Date |
| ____________________ | ____________________ | __________ |
| (Please Print) Name of Doctor | Signature of Doctor | Date |