Patient Medical History

Do you have or have you had any of the following? Please circle Y for yes or N for no on all three columns

Y N Heart Disease	**Y N** Heart Murmur/MVP	**Y N** Stroke
Y N Congenital Heart Lesions	**Y N** Rheumatic Fever	**Y N** Pacemaker
Y N Stent	**Y N** High Blood Pressure	**Y N** Anemia
Y N Prolonged Bleeding Disorder	**Y N** Low Blood Pressure	**Y N** Asthma
Y N Hay fever	**Y N** Sinus Trouble	**Y N** Epilepsy/Seizure
Y N Ulcers	**Y N** Liver Disease	**Y N** Jaundice
Y N Hepatitis Type _____	**Y N** Diabetes	**Y N** Arthritis
Y N Kidney Disease	**Y N** Radiation Therapy	**Y N** Tumor/Malignancy
Y N Cancer/Chemotherapy	**Y N** Immune Suppressed Disorder Type:	_____
Y N HIV/AIDS	**Y N** STI/Herpes	**Y N** Hearing loss
Y N Fainting Spells	**Y N** Glaucoma	**Y N** Depression
Y N Pregnant	**Y N** Nursing	**Y N** Taking Birth Control
Y N Artificial Joints: Where_____	_____	**Y N** Implants (cosmetic)(medical) (dental)
Y N Thyroid	**Y N** TB or Lung Disease	**Y N** E-cigarettes/ Vape
Y N Smoke/ chew Tobacco	_____ per day Years:_____	Have you quit? **Y N** When:_____
Y N Substance Abuse: What_____	_____ How often:_____	Have you quit? **Y N** When:_____

Y N Do you take Fosamax, Boniva, Actonel, Aredia, Zometa, etc. For Osteoporosis or any other condition?

Y N Had major Surgery? Year: _____ Type:_____ Year:_____ Type:_____

Are You Allergic to any of the following? (Please Circle)

Aspirin Ibuprofen Sulfa Drugs Penicillin Codeine Latex Local Anesthetics

Other allergies to medications: _____

Please List the medications you are currently taking with dosage and for what condition (Including over the counter medication & Aspirin)

RX:_____ Condition_____ How often?_____
RX:_____ Condition_____ How often?_____
RX:_____ Condition_____ How often?_____
RX:_____ Condition_____ How often?_____

Primary Medical Care Doctor: _____ Phone: _____

Patient Dental History

What is the reason for your appointment today? _____
Previous Dentist_____ Last Visit_____ Last Cleaning_____
Are you nervous about seeing the dentist? Y N Please Explain _____
How often do you brush? _____ Floss?_____
(Please Circle)

Y N I clench or grind my teeth during the day or while sleeping	**Y N** My gums feel tender or sore
Y N I My gums Bleed while brushing or flossing	**Y N** I have eating problems
Y N I have had orthodontics	**Y N** I have had gum Surgery
Y N I have had oral surgery	**Y N** I prefer tooth colored fillings

Y N Would you like to change anything about your smile? Explain? _____
What are you dental priorities?_____

Consent

I Understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the Providers at White Sands Family Dental to perform any necessary dental services, with my informed consent, that may be needed during diagnosis and treatment.

Signed:_____ Date:_____