ADA American Dental Association®

America's leading advocate for oral health

Today's Date: _____

Patient Dental & Medical Health History Information

To our patients: Our dental practice will keep your personal health information confidential. All of the answers on this form will be used only for our records and to help us provide treatment. Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name: First Name: Middle Name:

Home Phone: Cell Phone: Work Phone:

Email Address:

Mailing Address: City: State: Zip:

Date of Birth: / / Gender:

Occupation:

Emergency Contact: Name: Relationship: Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: Relationship:

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth? ☐

Does it hurt to chew, bite or swallow? ☐

Do your gums bleed when you brush or floss your teeth? ☐

Have you ever had periodontal (gum) treatments like scaling and root planing? ☐

Do you have, or have you ever had, any sores or growths in your mouth? ☐

Do you clench or grind your teeth? ☐

Does your jaw click, pop or hurt? ☐

Do you have earaches or neck pains? ☐

Does dental treatment make you nervous? ☐

Have you ever had a serious injury to your head or mouth? ☐

If yes, please describe what happened and when it happened: _____

Have you ever had problems with dental treatment in the past? ☐

If yes, please describe what happened: _____

Have you ever had a reaction to, or problem with, dental anesthesia? ☐

If yes, please describe what happened: _____

Are you unhappy with your smile? If yes, why? Please mark all that apply. ☐

☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth ☐ Other. Please describe: _____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions.

	Yes	No	?
Do you take any **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?**	☐	☐	☐
If yes, please list them here and include information about how much and how often you use each one. _____			
Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?	☐	☐	☐
If yes, what medication are you taking? _____			
Are you taking any medication to treat **osteoporosis** or Paget's disease? Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).	☐	☐	☐
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).	☐	☐	☐
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking **hormonal replacements**?	☐	☐	☐
Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)?	☐	☐	☐
Do you use **vaping products**?	☐	☐	☐
How many **alcoholic beverages** do you have per week? _____			
Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons?	☐	☐	☐
If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally			
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____			
WOMEN ONLY: Are you:			
Taking **birth control pills**?	☐	☐	☐
Pregnant? If yes, number of weeks: _____	☐	☐	☐
Nursing? If yes, number of weeks: _____	☐	☐	☐

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