MICHIGAN DENTAL SPECIALISTS
Periodontics
Oral Surgery
Dental Implants
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MEDICAL/DENTAL HISTORY

Name: ________________________ Nickname: _________________ Date of Birth: ________________ Date: ____________

Dental Information

Do your gums bleed when you brush or floss? ____________________ Y N
Are your teeth sensitive to cold, hot, sweets or pressure? __________ Y N
Is your mouth dry? ___________________________________ Y N
Have you had any periodontal (gum) treatments? _______________ Y N
Have you had orthodontic (braces) treatment? _________________ Y N
Is your water supply fluoridated? ___________________________ Y N
Do you drink bottle of filtered water? ________________________ Y N
Are you currently experiencing any dental pain or discomfort? _____ Y N

How often do you get your teeth cleaned? ________________________
When was your last dental cleaning? ____________________________
How often do you brush a day? _______________________________
Which of the following do you use on a daily basis:

- Manual tooth brush …………………………………………… Y N
- Electric tooth brush …………………………………………… Y N
- Waterpik ……………………………………………………… Y N
- Dental Floss…………………………………………………... Y N
- Rubber tip…………………………………………………….. Y N
- Proxy brush…………………………………………………… Y N
- Mouth rinse…………………………………………………… Y N

Do you have earaches or neck pains? ________________ Y N
Do you have clicking, popping or discomfort of the jaw? __ Y N
Do you brux or grind your teeth? ____________________ Y N
Do you wear a sleep/night guard? ___________________ Y N
Do you have sores or ulcers in your mouth? ____________ Y N
Do you wear dentures or partial dentures? ______________ Y N
Do you participate in active recreational activities? ______. Y N
Have you ever had serious injury to your head or mouth? _ Y N

What is the reason for your dental visit today:
____
____
____
____
____

Medical Information

Are you now under the care of a physician? Y N
Physician name: Phone #
______________________________________ ( ) ____________
Address/City/State/Zip
____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Y N
If yes, please list: ____
____
____
____

Have you had an orthopedic total joint (hip, knee, elbow, shoulder)… replacement? Y N
Date: ____________________
Do you premdicate prior to dental procedures……………………….. Y N

Are you taking or scheduled to begin taking an antiresorptive agent… (Fosamax®, Actonel, Boniva, Reclast, Prolia) for osteoporosis Y N

Since 2001, were you treated or are you presently scheduled to…….. begin treatment with an antiresorptive agent (Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Y N
Treatment date: ________________________________

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

- Local Anesthetics ……………………………………… Y N
- Penicillin ……………………………………………… Y N
- Clindamycin …………………………………………… Y N
- Erythromycin…………………………………………... Y N
- Codeine………………………………………………… Y N
- Narcotics ……………………………………………… Y N
  - If yes: ____________________________________
- Aspirin ………………………………………………… Y N
- Iodine …………………………………………………. Y N
- Sulfa …………………………………………………… Y N
- Latex ………………………………………………….. Y N
- Food …………………………………………………… Y N
- Seasonal ……………………………………………….. Y N
- Other ____________________________________ Y N

Are you taking any prescription or over the counter ……… medications? Y N
Please list the following medications:
____
____
____
____
____
____

Medical Conditions

Cardiovascular disease ………………..Y N
Angina ………………………………...Y N
Congestive heart failure ……………....Y N
Damaged heart ………………………..Y N
Heart attack……………………………Y N
Heart murmur ………………………...Y N
Low blood pressure…………………...Y N
High blood pressure…………………...Y N
Mitral valve prolapse…………………Y N
Pacemaker……………………………..Y N
A-Fib…………………………………..Y N
Abnormal bleeding…………………….Y N
Anemia ……………………………….Y N
Blood transfusion……………………...Y N
If yes, date: ________________
Hemophilia ……………………………Y N
Rheumatic fever……………………….Y N

AIDS or HIV infection ………………..Y N
Arthritis ……………………………….Y N
Autoimmune disease…………………..Y N
If yes: ______________________
Asthma ……………………………….Y N
Bronchitis ……………………………..Y N
Emphysema …………………………...Y N
Sinus trouble …………………………Y N
Tuberculosis ……………………….....Y N
Cancer/Chemo/Radiation treatment.......Y N
Diabetes Type I ....Y N
Diabetes Type II ....Y N
Gastrointestinal disease .... Y N
If yes: _____________________
Reflux/heartburn.................................. Y N
Ulcers .... Y N
Thyroid problems.................................Y N
Stroke... Y N

Glaucoma...Y N
Hepatitis, jaundice, liver disease...........Y N
Epilepsy..Y N
Fainting spells or seizures ....Y N
Neurological disorders..........................Y N
Specify: ___________________
Sleep disorder..Y N
Do you snore?.......................................Y N
Mental health disorder..........................Y N
Specify: ___________________
Kidney problems...................................Y N
Osteoporosis...Y N
Migraines/headaches.............................Y N

Other: ______________________________
____
____
____

Miscellaneous

Do you smoke tobacco? ....Y N
If yes, how many per day? ________
Do you chew tobacco?..........................Y N
Do you vape? ....Y N
Current or history of drug use? ....Y N
If yes, ______________________

Do you drink? .... Y N
Beer...Y N
Wine...Y N
Liquor.. Y N
If yes, how many per day________

Women

Are you pregnant? ....Y N
Are you nursing? ....Y N
Do you take birth control?.................. Y N

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature: ____

Date: ________________

Doctor Signature: __________________________________

Health History Update

Date: ____________

New health issues:
____
____
____
____

New medications:
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____
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Patient Signature: _______________

Doctor Signature: _______________

Health History Update

Date: ____________

New health issues:
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New medications:
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Patient Signature: _______________

Doctor Signature: _______________

Health History Update

Date: ____________

New health issues:
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New medications:
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Patient Signature: _______________

Doctor Signature: _______________