VIRDIDENTAL

Medical History Form

Patient information:

Patient Fist Name: _____ Last name: _____ MI: _____

Gender:_____ Preferred pronouns:_____ Marital Status_____

Date of Birth: ____/_____/_____ SSN_____-_____-_____ Phone #: (_____) _____-_____

Address _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Height: _____ Weight: _____

Emergency contact: _____ Relationship: _____ Phone #: (_____) _____-_____

If you are completing this form for someone other than yourself:

Name: _____ Relationship to patient: _____

Dental Information: **Yes, No, Unknown**

BITE AND JAW JOINT

Does your jaw ever have pain, popping/cracking, or locking up? Y □ N □ U □

Do you ever have pain in your facial muscles or have difficulty chewing hard, dry foods? Y □ N □ U □

Are your teeth becoming more crooked, crowded, or overlapped? Y □ N □ U □

Do you clench or grind your teeth together? Y □ N □ U □

GUM AND BONE

Do your gums bleed when you brush? Y □ N □ U □

Have you had periodontal (gum) treatments? Y □ N □ U □

Is there anyone in your family with a history of periodontal disease? Y □ N □ U □

Are your teeth sensitive to sweets? Y □ N □ U □

Do you have earaches or neck pain? Y □ N □ U □

Do you wear removable dental appliances? Y □ N □ U □

How many times a day do you floss your teeth? _____

How many times a day do you brush your teeth? _____

Yes, No, Unknown

PERSONAL HISTORY

Have you ever had complications from past dental treatment? Y □ N □ U □

If yes, explain: _____

Have you ever had trouble getting numb or had any reactions to local anesthetic? Y □ N □ U □

Have you ever had orthodontic(braces) treatment?

Have you ever had any teeth removed or lost teeth due to injury or facial trauma? Y □ N □ U □

Any current dental problems? Y □ N □ U □

If yes, explain:_____

Date of most recent treatment (other than cleaning): _____

Date of last dental x-rays: _____

Have you ever bleached (whitened) your teeth? Y □ N □ U □

Are you fearful of dental treatment? Y □ N □ U □

Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? Y □ N □ U □

Do you have trouble taking care of your teeth? Y □ N □ U □

Medical Information:

If you answer yes to any of the 3 items below, please stop and return this form to the front desk.

Have you had any of the following diseases or problems?

Active Tuberculosis Y □ N □ U □

Persistent cough greater than a 3-week duration? Y □ N □ U □

Cough that produces blood? Y □ N □ U □

Are you in good health? Y □ N □ U □

Has there been any changes in your general health within the last year? Y □ N □ U □

Are you now under a physician's care? Y □ N □ U □

If yes, what is/are the condition(s) being treated?

_____

Are you taking or have you recently taken any medication(s) including non-prescription medications? Y □ N □ U □

If yes, what medications are you taking?

Prescribed: _____

_____

_____

Over the counter: _____

_____

Vitamins/natural supplements: _____

_____

Date of last physical examination? _____

Physician's Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Secondary Physician: _____

Address: _____

City: _____ State: ____ Zip: _____

Do you drink alcoholic beverages? Y □ N □ U □

If yes, how much alcohol did you drink in the last 24 hours? _____ In the past week? _____

Have you had any serious illness, operation or been hospitalized in the last 5 years? Y □ N □ U □

If so, what was the illness or problem?

_____

_____

_____

Are you drug or alcohol dependent? Y □ N □ U □

If yes, have you received treatment? Y □ N □ U □

Do you use drugs/substances for recreational purposes? Y □ N □ U □

If yes, please list _____

Frequency of use: _____ # of years: _____

VIRDIDENTAL

Are you taking or have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or Pen-fen (fenfluramine-phentermine combination)? Y □ N □ U □

Do you use Tobacco (smoking, snuff or chew?) Y □ N □ U □

If yes, how interested are you in quitting? (circle one)

Very/ Somewhat/ Not interested

Do you wear contact lenses? Y □ N □ U □

Have you ever had an orthopedic total joint Replacement? (hip, knee, elbow, finger)? Y □ N □ U □

If yes, when was the operation done? _____

If yes, have you had any complications or difficulties

_____

Name of physician: _____

Name of physician's office: _____

Phone #: (_____) _____- _____

Have you ever been advised to pre-medicate or take an antibiotic prior to dental treatment? Y □ N □ U □

If yes, what medication? _____

If yes, what dosage? _____

Do you have? (mark all that apply)

Hemophilia Y □ N □ U □

Hepatitis, jaundice or liver disease Y □ N □ U □

Recurrent infections Y □ N □ U □

If yes, indicate the type of infection?_____

_____

Kidney problems Y □ N □ U □

Mental Health Disorders Y □ N □ U □

If yes, please specify: _____

Malnutrition Y □ N □ U □

Night sweats Y □ N □ U □

Neurological disorders Y □ N □ U □

If yes, please specify: _____

Osteoporosis Y □ N □ U □

Persistent swollen glands in neck Y □ N □ U □

Respiratory issues Y □ N □ U □

If yes, specify: __Emphysema __Bronchitis _____other

Tuberculosis Y □ N □ U □

Systemic lupus erythematosus Y □ N □ U □

Abnormal bleeding Y □ N □ U □

AIDS or HIV infection Y □ N □ U □

Anemia Y □ N □ U □

Arthritis Y □ N □ U □

Rheumatoid arthritis Y □ N □ U □

Asthma Y □ N □ U □

Ulcers Y □ N □ U □

Excessive urination Y □ N □ U □

Are you allergic to or have you had a reaction to? Yes, No, Unknown

Local anesthetics Y □ N □ U □

Aspirin Y □ N □ U □

Antibiotics (please specify) Y □ N □ U □

Barbiturates, sedatives, sleeping pills Y □ N □ U □

Sulfa drugs Y □ N □ U □

Codeine or other narcotics Y □ N □ U □

Latex Y □ N □ U □

Iodine Y □ N □ U □

Hay Fever/Seasonal Y □ N □ U □

Animals Y □ N □ U □

Food (specify)_____ Y □ N □ U □

Metals (specify)_____ Y □ N □ U □

Other (specify)_____ Y □ N □ U □

If yes responses, specify type of reaction:

_____

_____

_____

Do you have? (mark all that apply)

Blood transfusion? Date if yes_____ Y □ N □ U □

Cancer/Chemotherapy/Radiation Y □ N □ U □

Cardiovascular problems? If yes, specify below Y □ N □ U □

___Angina ___Heart murmur

___Arteriosclerosis ___High Blood Pressure

___Artificial valves ___Low Blood Pressure

___Mitral valve prolapse ___Heart attack

___Pacemaker ___Damaged valves

___Congestive heart failure ___Congenital heart defects

___ Coronary artery disease ___Rheumatic heart disease/Rheumatic fever

Chest pain upon exertion Y □ N □ U □

Chronic pain Y □ N □ U □

Immunosuppression Y □ N □ U □

Diabetes Y □ N □ U □ If yes, circle type: 1 2

Dry mouth Y □ N □ U □

Eating disorder Y □ N □ U □

Epilepsy Y □ N □ U □

Fainting spells or seizures Y □ N □ U □

Gastrointestinal disease Y □ N □ U □

G.E.R.D/ Heartburn Y □ N □ U □

Glaucoma Y □ N □ U □

Stroke Y □ N □ U □

Thyroid problems Y □ N □ U □

Women Only

Are you or could you be pregnant? Y □ N □ U □

Nursing? Y □ N □ U □

Taking birth control bills or hormone replacement? Y □ N □ U □

Any other conditions not listed that we should know about?

Please explain:_____

_____

Anything else you feel is important for us to know?

_____

_____

I have read the questions above and acknowledge that my questions, if any, *about inquiries set forth have been answered to my satisfaction. I will* not *hold my dentist or their staff responsible for any action they take or do* not *take because of errors or omissions in completion of this form.*

Patient Signature: _____ Date: _____ Dr's signature:_____Date: _____