Medical and Dental History

Name: _____

Date of Birth: _____

Today's Date: _____

Emergency Contact

Name	Relationship	Phone number

Medical Information

Circle what best describes your current physical health: □ good □ fair □ poor	
Physician name	
Date of last physical exam	Office phone
Has there been any change in your general health within the last year? □Yes □No If yes, what condition is being treated?	
Pharmacy name	Pharmacy phone
Have you had a serious illness, operation, or been hospitalized in the past 5 years? □Yes □No If yes, please describe.	
Do you use tobacco or nicotine? □Yes □No If yes, what kind and how much/often?	
Do you consume more than 2 alcoholic beverages a day? □Yes □No	
List all prescribed and over-the-counter medications with their doses. _____ _____	
Have you had an allergic reaction? □Yes □No If yes, list what has caused an allergic reaction or sensitivity.	
Have you been vaccinated against COVID-19? □Yes □No	

Dental Information

Do your gums bleed when you brush or floss?	□Yes □No	Are your teeth sensitive?	□Yes □No
Does food or floss catch between your teeth?	□Yes □No	Is your mouth dry?	□Yes □No
Have you had periodontal (gum) treatments?	□Yes □No	Have you had orthodontic (braces) treatment?	□Yes □No
Do you have any clicking or discomfort in the jaw?	□Yes □No	Do you grind your teeth?	□Yes □No
Are you currently having dental pain?	□Yes □No	Do you get sores or ulcers in your mouth?	□Yes □No
Have you ever had any problems associated with previous dental treatment? □Yes □No			
How often do you see your dentist? □ 3 months □ 6 months □ yearly □ other			
When were your teeth last cleaned?	How often do you brush? Floss?		
Do you use any other dental products or tools?			
Does dental treatment make you nervous? □ no □ slightly □ moderately □ extremely			
What is your reason for today's visit?			

Medical History

Please mark (X) your response to indicate if you have or have had any of the following conditions.

Autoimmune
HIV/AIDS □Yes □No
Rheumatoid arthritis □Yes □No
Lupus □Yes □No
Hemophilia □Yes □No
Other autoimmune condition
Specify:

Bone
Arthritis □Yes □No
Joint replacement /artificial joint □Yes □No
Date:
Osteoporosis □Yes □No
Bisphosphonate use □Yes □No

Digestive System
Acid reflux □Yes □No
Ulcers □Yes □No
Hepatitis □Yes □No
Celiac disease □Yes □No
Crohn's disease □Yes □No
Ulcerative colitis □Yes □No
Eating disorder □Yes □No
Food allergies □Yes □No
Specify:

Respiratory System
Asthma □Yes □No
COPD □Yes □No
Emphysema □Yes □No
Bronchitis □Yes □No
Tuberculosis □Yes □No
Sinusitis □Yes □No
Sleep apnea □Yes □No
Difficulty breathing when lying down □Yes □No

Ears
Hearing impairment □Yes □No
Vertigo □Yes □No

Eyes
Glaucoma □Yes □No
Wears contacts □Yes □No

Genitourinary System
Kidney disease □Yes □No
Excessive urination □Yes □No
Sexually transmitted infections □Yes □No
Specify:

Endocrine
Diabetes □Yes □No
Type 1
Type 2
Gestational
Family History
Thyroid problems □Yes □No
PCOS □Yes □No

Nervous System
Seizures/epilepsy □Yes □No
Stroke □Yes □No
Dizziness/fainting □Yes □No
Migraines. □Yes □No
Sleep disorder. □Yes □No
Mental illness. □Yes □No
Specify:

Cardiovascular System
Heart murmur □Yes □No
Artificial heart valve □Yes □No
Arteriosclerosis □Yes □No
Congestive heart failure. □Yes □No
Heart attack □Yes □No
High blood pressure □Yes □No
Congenital heart defects □Yes □No
Pacemaker □Yes □No
Atrial fibrillation □Yes □No
Anemia □Yes □No
Blood transfusion □Yes □No
Heart surgery □Yes □No
High cholesterol □Yes □No
Use of Fen-Phen ® □Yes □No
Abnormal or excessive bleeding. □Yes □No
Bruise easily □Yes □No
Anticoagulant/"blood thinner" use □Yes □No

Women Only – are you
Pregnant? □Yes □No
Due date:
Using birth control? □Yes □No
Nursing? □Yes □No

Other
Chemotherapy/Radiation/ Cancer treatment □Yes □No
Organ transplant □Yes □No
Recreational drug use □Yes □No
Specify:

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? □Yes □No If yes, please explain:

Do you have any disease, condition, or problem not listed that we should know about? □Yes □No If yes, please explain:

Is there anything we can do to make your experience with our office more pleasant?

I give permission to Fay Periodontal Associates to administer medications and anesthetics necessary for proper periodontal and dental care. Permission is also given to share information about my health care and treatment to my referring dentist and insurance company as needed. I understand that I am fully responsible for all charges whether covered, not covered, or denied by insurance as allowable per the insurance provider contract. Payment is due at the time of service unless prior arrangements are made.

The information I have provided is correct to the best of my knowledge. If changes occur (ie. Modification in prescriptions, new diagnoses or surgeries), I will notify Fay Periodontal Associates. I understand the importance of a truthful health history, including medication use, and that my dental team 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 Fay Periodontal Associates 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 of Patient/Legal Guardian: _____ Date: _____