All Smiles Tampa Bay
Family & Cosmetic Dentistry

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Medical History

Patient Name: _____ Date of Birth: _____

Dental health is related to your overall health. Medical problems and medications impact your oral health and recommended dental treatment. To help us ensure you have the optimum care, please answer the following questions below as accurately as possible.

Are you currently under the care of a physician? ☐Yes ☐No Please explain: _____

Physician Name: _____ Phone Number: _____

Have there been any changes in your health in the past year? ☐Yes ☐No Please explain: _____

Have you ever had a serious head or neck injury? ☐Yes ☐No Please explain: _____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No Please explain: _____

Do you use tobacco (smoking, chew, snuff)? ☐Yes ☐No Are you interested in quitting? _____

Do you use drugs or controlled substances? ☐Yes ☐No Are you interested in quitting? _____

Have you had a total joint replacement? ☐Yes ☐No Type of joint (hip, knee, etc): _____ Date of surgery: _____

Have you ever had infection or complications with your prosthetic joint? ☐Yes ☐No Please explain: _____

Do you have artificial heart valves? ☐Yes ☐No Please explain: _____

Has a physician recommended that you take antibiotics prior to dental treatment? ☐Yes ☐No Please explain: _____

Women only, are you: Taking oral contraceptives? ☐Yes ☐No Pregnant/Trying to get pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No

Do you have, or have you had, any of the following?

- ☐ Seasonal or Environmental Allergies
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Arthritis (☐RA or ☐osteo)
- ☐ Asthma
- ☐ Bleeding/Blood problems
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes (☐Type I or ☐Type II)
- ☐ Dizziness/Fainting
- ☐ Dry Mouth
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur/MVP
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Immunosuppression
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Nervous Disorders
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stomach Problems/Ulcers
- ☐ Stroke
- ☐ Thyroid problems (☐hyper/☐hypo/☐other)
- ☐ Tuberculosis

Do you have any other health issues not listed above? _____

What **medications** are you taking? (prescription and over-the-counter) _____

_____

Have you ever taken Fosamax, Actonel or Boniva (alendronate sodium, risedronate or ibandronate)? ☐Yes ☐No

If yes, how long? _____ What form? ☐oral (pill) ☐IV

Do you have any **allergies**? ☐Aspirin ☐Acrylic ☐Codeine ☐Latex ☐Metals ☐Penicillin ☐Other: _____

Dental History

Previous Dentist: _____ Date of last x-rays? _____

When was your last dental visit? _____ What was done? _____

Please check the following dental conditions that apply to you:

- ☐ Gums bleed when you brush or floss
- ☐ Teeth sensitive to cold, hot, sweets or pressure
- ☐ Previous periodontal/gum treatments
- ☐ Teeth are or feel loose
- ☐ Bad breath or Dry mouth
- ☐ Food collects between teeth
- ☐ Problems chewing gum
- ☐ Problems chewing bagels or other hard foods
- ☐ Teeth have changed in the last 5 years, becoming shorter, thinner or worn
- ☐ Teeth are crowding or developing spaces
- ☐ Have more than one bite or clench/squeeze to make your teeth fit together
- ☐ Problems with sleep or wake up with an awareness of your teeth
- ☐ Snore or have a sleep disorder (apnea)
- ☐ Tension headaches or sore teeth
- ☐ Wear or have worn a bite appliance
- ☐ Current or previous orthodontic treatment (braces)

Do you have problems with your jaw joint? ☐ Pain ☐ Clicking or grinding sounds ☐ Limited opening ☐ Locking ☐ Popping

Do you currently have any ☐ dental implants, ☐ dentures or ☐ partials?

How do you feel about the appearance of your teeth? If you could change anything about your teeth, mouth or smile, what would it be? _____

_____

_____

I have answered the questions on this form to the best of my knowledge. I understand there may be a risk to my health or treatment if I do not fully disclose any medical or dental information. I understand it is my responsibility to inform this office of any changes.

Signature _____ Date _____