West Arvada Family Dental
18068 W 92nd Ln #100
Arvada CO - 80007-0000
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Medical History Form

Patient Information

Name

Gender

DOB

Phone No

Conditions

	Yes	No	Dont Know
Abnormal bleeding.	☐	☐	☐
Anemia	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Autoimmune disease	☐	☐	☐
Bronchitis	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Chronic pain	☐	☐	☐
Congenital heart disease (CHD) Repaired CHD with residual defects	☐	☐	☐
Damaged heart valves	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
Heart attack	☐	☐	☐

	Yes	No	Dont Know
AIDS or HIV infection	☐	☐	☐
Angina	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Congenital heart disease (CHD) Repaired (completely) in last 6 months	☐	☐	☐
Congenital heart disease (CHD) Unrepaired, cyanotic CHD	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Do you snore?	☐	☐	☐
Emphysema	☐	☐	☐
Excessive urination	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

Conditions

	Yes	No	Dont Know
Hemophilia	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Pacemaker.	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sinus trouble	☐	☐	☐
Stroke	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐

	Yes	No	Dont Know
Heart murmur	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Mitral valve prolapse.	☐	☐	☐
Night sweats	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Recurrent Infections	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sleep disorder	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐

Other Conditions

_____

Allergies

	Yes	No	Dont Know
Animals	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Congestive heart failure	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Latex (rubber)	☐	☐	☐
Metals	☐	☐	☐
Sulfa drugs	☐	☐	☐

	Yes	No	Dont Know
Aspirin	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Food	☐	☐	☐
Iodine	☐	☐	☐
Local anesthetics	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐

Other Allergies

_____

Dental Questionnaire

Dental Information

1.	Do your gums bleed when you brush or floss?	:
2.	Are your teeth sensitive to cold, hot, sweets or pressure?	:
3.	Have you had any periodontal (gum) treatments?	:
4.	Have you ever had orthodontic (braces) treatment?	:
5.	Have you had any problems associated with previous dental treatment?	:
6.	Do you drink bottled or filtered water?	:
7.	Are you currently experiencing dental pain or discomfort?	:
8.	Do you have any clicking, popping or discomfort in the jaw?	:
9.	Do you grind your teeth?	:
10.	Do you have sores or ulcers in your mouth?	:
11.	Do you wear dentures or partials?	:
12.	Have you ever had a serious injury to your head or mouth?	:
13.	Date of your last dental exam:	:
14.	What was done at that time?	:
15.	Date of last dental x-rays:	:
16.	What is the reason for your dental visit today?	:
17.	How do you feel about your smile?	:
18.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	:
19.	Do you have any disease, condition, or problem not listed above that you think I should know about?	:
20.	Please explain:	:

Medical Questionnaire

Medical Information

1.	Are you now under the care of a physician?	:
2.	Physician Name:	:
3.	Are you in good health?	:
4.	Has there been any change in your general health within the past year?	:
5.	If yes, what condition is being treated?	:
6.	Date of last physical exam:	:
7.	Have you had a serious illness, operation or been hospitalized in the past 5 years?	:
8.	If yes, what was the illness or problem?	:
9.	Are you taking or have you recently taken any prescription or over the counter medicine(s)?	:
10.	If so, please list all medications, including vitamins, natural or herbal preparations and/or dietary supplements:	:
11.	Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	:
12.	Date:	:
13.	If yes, have you had any complications?	:
14.	Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax® , Actonel® , Atelvia, Boniva® , Reclast, Prolia) for osteoporosis or Paget's disease?	:
15.	Date Treatment began:	:
16.	Do you use controlled substances (drugs)?	:
17.	Do you use tobacco (smoking, snuff, chew, bidis)?	:
18.	If so, how interested are you in stopping? (fill in the blank) Very / Somewhat / Not interested	:
19.	Do you drink alcoholic beverages?	:

WOMEN ONLY Are you:

1.	Pregnant?	:
2.	Number of weeks:	:
3.	Taking birth control pills or hormonal replacement?	:
4.	Nursing?	:

By signing below, I certify that all the above information is true to the best of my knowledge. I understand the importance of this information and that the practice will rely on this information for treating me. I will not hold the practice or any member/staff of the practice, 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 or Responsible Party

Date