DENTAL / MEDICAL HISTORY

Patient Name_____ Today's Date_____

Date of birth_____ Physician's Name _____

Dental History

Previous Dentist_____ Date of last X-Rays_____

City, State_____ Times a day you brush? _____

Date of last Dental Visit_____ Times a day you floss? _____

Reason for today's visit_____

Pre-Medication Required? ☐YES ☐NO

Reason_____Type_____Dosage_____

CURRENT MEDICATIONS

Medication	Dosage	Frequency

Allergies

Tobacco Use

Tobacco user?..... ☐Yes ☐No

Type_____

Amount_____

Number of years_____

Former Tobacco user?..... ☐Yes ☐No

Type_____

Amount_____

Year Quit_____

Any allergies to:	YES	NO
Local anesthetics (eg. Novocaine)?		
Penicillin?		
Sulfa drugs?		
Barbiturates (eg. sleeping pills)?		
Iodine?		
Latex?		
Aspirin?		
Codeine?		
Tetracycline?		
Erythromycin?		
Other?		

***List other drugs/materials you are allergic to*:**

_____

_____

Women Only

Are you Pregnant?..... ☐Yes ☐No

Due date_____

Are you Nursing?..... ☐Yes ☐No

Taking oral contraceptives?..... ☐Yes ☐No

PLEASE TURN OVER ➡

PAST AND CURRENT MEDICAL CONDITIONS

Medical conditions and medications can cause oral health problems, please disclose all information.
All patient information is confidential.

MARK ALL THAT APPLY, PAST OR PRESENT:

CONDITION	YES	NO
Under physician's care? Details:		
Hospitalization in last 5 years? Details:		
Past use of Fen-Phen?		
Heart trouble / disease?		
Rheumatic fever?		
Heart murmur?		
Mitral valve prolapse?		
Heart Surgery?		
Artificial heart valves?		
Pacemaker and/or defibrillator?		
Artificial joints?		
History of organ transplant?		
High/Low blood pressure?		
Stroke?		
Bleeding problem?		
Hemophilia?		
Anemia?		
Leukemia?		
Lung disease?		
Emphysema?		
Shortness of breath?		
Asthma?		
Sleep apnea?		
Tuberculosis?		
Sinus trouble?		
Cancer?		
Radiation treatment to head/neck?		

CONDITION	YES	NO
Past use of Bisphosphonates (eg. Aredia / Fosomax)?		
History of infective endocarditis?		
Chemotherapy?		
Kidney disease?		
Dialysis?		
Eating disorder?		
G.I. problems: reflux? Ulcer?		
Immunological disease?		
Sjogrens disease?		
Fibromyalgia?		
Other autoimmune disease (eg. lupus, pemphilus)?		
Jaw pain?		
Arthritis or other joint disorders?		
Diabetes? Type: Controlled? Y N		
Hypoglycemia?		
Severe/frequent headaches?		
Diagnosed depression?		
Neurologic disorders?		
Convulsions?		
Epilepsy / seizures?		
Fainting / dizziness?		
AIDS / HIV positive?		
Sexually transmitted disease?		
Hepatitis?		
Thyroid disease?		
Glaucoma?		
Alcohol or chemical dependency?		

Any other conditions we should know about? _____
_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform the office of Jeffrey J. Tibbs, DDS, PA of any changes to the information I have provided.

Signature_____**Date**_____

___adult patient ___parent or guardian