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Oakland, CA 94610

Medical-Dental History Form

Patient Name: _____ Date of Birth: _____

___ **YES** ___ **NO** **Is anything bothering you with your teeth or gums? Any concerns? If yes, list below:**

___ **YES** ___ **NO** **Is there anything you'd like to change cosmetically with your teeth? If yes, list below:**

Do you have any of the following?

___ History of deep cleaning
___ Jaw or TMJ Pain
___ Dry Mouth
___ Clenching/Grinding habit
___ Tooth Pain
___ Sensitivity to Hot or Cold

Do you have or have you had any of the following? (Please check all that apply)

___ Heart Disease
___ Heart Attack
___ Artificial Joint
___ Stomach Ulcers
___ High Blood Pressure
___ Seizures
___ Pacemaker
___ Tumors or Cancer
___ History of Radiation
___ Stroke
___ Kidney Disease
___ Liver Disease
___ Osteoporosis
___ Heart Valve Replacement
___ Hepatitis
___ Diabetes
___ Anemia
___ AIDS/HIV
___ Asthma
___ Blood Disorders
___ Tobacco use

___ **YES** ___ **NO** Are you pregnant?

___ **YES** ___ **NO** Have you ever been pre-medicated with antibiotics prior to dental treatment?

___ **YES** ___ **NO** Have you had any problems with local anesthetic or trouble getting numb?

___ **YES** ___ **NO** Have you ever had an adverse reaction to penicillin or amoxicillin?

___ **YES** ___ **NO** Have you ever had an adverse reaction to ibuprofen, Advil or Aleve?

___ **YES** ___ **NO** Have you ever taken bisphosphonate drugs (for osteoporosis or cancer treatment)?

Please list ALL medications you are taking:

Please list any allergies you have:

_____ _____

Patient signature and date

Provider signature and date