T. Booth Haley DDS
298 Grand Avenue, Ste 200,
Oakland, CA 94610

Medical-Dental History Form

Patient Name: _____ Date: _____

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

___ YES ___ NO Do you have any cosmetic concerns with your teeth? If yes, list below:

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

___ Gum Disease/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 or could you be 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 oral or IV Bisphosphonates drugs?

Please list ALL medications you are taking:

Please list any allergies you have:

_____ _____

Patient signature and date

Dentist signature and date