

# Patient Medical History

*Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely and accurately. If you have any questions or need assistance, please ask - we will be happy to help.*

- |  |   |  |   |
|--|---|--|---|
|  | <b>Yes No</b>                                     |  | <b>Yes No</b>                                     |
| 1. Are you taking any prescription medicine?<br>If yes, what medication(s) are you taking?<br>_____<br>_____ | <input type="checkbox"/> <input type="checkbox"/> | 7. Are you under medical treatment now?  | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Do you take Aspirin on a daily basis?   | <input type="checkbox"/> <input type="checkbox"/> | 8. Have you been hospitalized for any surgical operation or serious illness in the past 5 years?       | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Do you take Fish Oils/Omega 3 on a daily basis?   | <input type="checkbox"/> <input type="checkbox"/> | 9. Do you wear contact lenses?   | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Do you see a cardiologist?  | <input type="checkbox"/> <input type="checkbox"/> | 10. Are you allergic to or have had any reactions to the following:<br>Penicillin or other Antibiotics | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Do you smoke?   | <input type="checkbox"/> <input type="checkbox"/> | Other  | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Do you consume alcohol?   | <input type="checkbox"/> <input type="checkbox"/> | 11. Women Only:  |   |
|  |   | a) Are you pregnant or think you may be pregnant?  | <input type="checkbox"/> <input type="checkbox"/> |
|  |   | b) Are you nursing?  | <input type="checkbox"/> <input type="checkbox"/> |
|  |   | c) Are you taking birth control pills?   | <input type="checkbox"/> <input type="checkbox"/> |

## 12. Do you have or have you had any of the following:

- |                       |   |                         |   |                         |   |
|-----------------------|---|-------------------------|---|-------------------------|---|
|                       | <b>Yes No</b>                                     |                         | <b>Yes No</b>                                     |                         | <b>Yes No</b>                                     |
| High Blood Pressure   | <input type="checkbox"/> <input type="checkbox"/> | Stomach Troubles/Ulcers | <input type="checkbox"/> <input type="checkbox"/> | Artificial Heart Valves | <input type="checkbox"/> <input type="checkbox"/> |
| Heart Attack/Stroke   | <input type="checkbox"/> <input type="checkbox"/> | Cardiac Pacemaker       | <input type="checkbox"/> <input type="checkbox"/> | Sinus Problems          | <input type="checkbox"/> <input type="checkbox"/> |
| Irregular Heartbeat   | <input type="checkbox"/> <input type="checkbox"/> | Psychiatric Care        | <input type="checkbox"/> <input type="checkbox"/> | Radiation Therapy       | <input type="checkbox"/> <input type="checkbox"/> |
| Seizures/Fainting     | <input type="checkbox"/> <input type="checkbox"/> | Angina/Chest Pain       | <input type="checkbox"/> <input type="checkbox"/> | Glaucoma                | <input type="checkbox"/> <input type="checkbox"/> |
| Asthma                | <input type="checkbox"/> <input type="checkbox"/> | Bleeding Problems       | <input type="checkbox"/> <input type="checkbox"/> | Liver Disease           | <input type="checkbox"/> <input type="checkbox"/> |
| Depression            | <input type="checkbox"/> <input type="checkbox"/> | Anemia                  | <input type="checkbox"/> <input type="checkbox"/> | Heart Trouble           | <input type="checkbox"/> <input type="checkbox"/> |
| Drug Dependence       | <input type="checkbox"/> <input type="checkbox"/> | Emphysema/COPD          | <input type="checkbox"/> <input type="checkbox"/> | Respiratory Problems    | <input type="checkbox"/> <input type="checkbox"/> |
| Leukemia/Lymphoma     | <input type="checkbox"/> <input type="checkbox"/> | Cancer                  | <input type="checkbox"/> <input type="checkbox"/> | Osteoporosis            | <input type="checkbox"/> <input type="checkbox"/> |
| Diabetes              | <input type="checkbox"/> <input type="checkbox"/> | Rheumatoid Arthritis    | <input type="checkbox"/> <input type="checkbox"/> | Vascular Disease        | <input type="checkbox"/> <input type="checkbox"/> |
| Kidney Diseases       | <input type="checkbox"/> <input type="checkbox"/> | Joint Replacement       | <input type="checkbox"/> <input type="checkbox"/> | Bruise Easily           | <input type="checkbox"/> <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> <input type="checkbox"/> | Hepatitis               | <input type="checkbox"/> <input type="checkbox"/> | Other _____             |   |
| Thyroid Problem       | <input type="checkbox"/> <input type="checkbox"/> | Easily Winded           | <input type="checkbox"/> <input type="checkbox"/> | Other _____             |   |

# Patient Dental History

- |  |   |  |   |
|--|---|--|---|
|  | <b>Yes No</b>                                     |  | <b>Yes No</b>                                     |
| 1. Do your gums bleed while brushing or flossing?        | <input type="checkbox"/> <input type="checkbox"/> | 10. Does food get stuck between your teeth?  | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Are your teeth sensitive to cold liquids/foods?       | <input type="checkbox"/> <input type="checkbox"/> | 11. Do you have a problem with gagging?  | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Do you feel pain in any of your teeth?                | <input type="checkbox"/> <input type="checkbox"/> | 12. Do you feel very nervous about having dental treatment?                          | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Do you feel you have bad breath?                      | <input type="checkbox"/> <input type="checkbox"/> | 13. Do you clench or grind your teeth?   | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Do you have any sores or bumps in or near your mouth? | <input type="checkbox"/> <input type="checkbox"/> | 14. Have you ever been treated for gum disease?                                      | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Have you noticed any loosening of your teeth?         | <input type="checkbox"/> <input type="checkbox"/> | 15. Toothbrush use <input type="checkbox"/> Electric <input type="checkbox"/> Manual |   |
| 7. Have you noticed any shifting of your teeth?          | <input type="checkbox"/> <input type="checkbox"/> | 16. How long since your last cleaning? _____   |   |
| 8. Have you had any head, neck, or jaw injuries?         | <input type="checkbox"/> <input type="checkbox"/> | 17. Physician's Name _____   |   |
| 9. Do you experience any difficulty in chewing?          | <input type="checkbox"/> <input type="checkbox"/> | 18. Physician's Phone _____  |   |

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such dental care to third party payors and /or health practitioners.

While I understand that I am ultimately responsible for all dental treatment fees, I would appreciate the office's assistance in submitting to my insurance company for reimbursement. I authorize release of any information concerning my (or my child's) health care, advice, or treatment provided for the purpose of evaluating and administering claims for insurance benefits and securing payment for treatment. I also authorize payment of insurance benefits be made directly to Dr. VanAealst's Office.

X \_\_\_\_\_  
Signature of patient or parent if minor Date

Doctor's Notes _____ _____
X _____ Signature of Doctor <span style="float: right;">Date</span>