Medical History

About You: **Today's Date**_____

Name_____ Preferred Name _____ Birth date _____Age____SS#_____ Female Male

Address_____City_____State_____Zip_____

Phone # Mobile (____)_____ Home (____)_____ Work (____)_____

Marital Status Single Married Separated Divorced Widowed

Preferred way to receive reminder of upcoming appointments Mobile Home Work Text Email

Best time to reach you _____ AM PM

Email address_____ (only for appointment reminders)

Why have you come to the dentist today? _____ Are you currently in pain? Yes No

Employed Full-Time Part-Time Retired Not Employed Student _____(School Name)

Employer_____Address_____

Emergency Contact_____Phone#_____Relation:_____

Physician's Name _____ Phone #_____City_____ Date of last visit: _____

Pharmacy Name_____ Location_____ Phone Number_____

Medications:

Please list any and ALL Medications you are taking including prescription, over the counter, herbal, vitamins and minerals, weight loss aids, cold or allergy medicine, pain medicine, etc:

_____

_____

_____

Women:

Are you taking Birth Control Pills?	Yes	No	
…Hormone Replacement?	Yes	No	
Are you Pregnant?	Yes	No	Week #_____
Are You Nursing?	Yes	No	

Allergies:

Y	N	Penicillin	Y	N	Dental Anesthetics (Novocaine)
Y	N	Aspirin	Y	N	Sulfa drugs
Y	N	Tetracycline	Y	N	Latex
Y	N	Codeine	Y	N	Other

Please list any others not mentioned including food allergies:_____

_____

Do you smoke?	Y	N	Pks per day_____ Number of Years_____
Do you use any other tobacco products? (Pipe, cigars, snuff, dip, chew, vaping)	Y	N	Amount Daily_____

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Do you or have you ever had any of the following diseases or conditions?
(**Please circle either Y or N for each condition**)

Y	N	High or Low Blood Pressure
Y	N	Heart Attack
Y	N	Rheumatic or Scarlet Fever
Y	N	Congenital Heart Defect
Y	N	Mitral Valve Prolapse
Y	N	Pacemaker
Y	N	Have you been advised to take antibiotics before dental appts?
Y	N	Heart Surgery
Y	N	Artificial Heart Valve, replacements
Y	N	High Cholesterol
Y	N	Diabetes Type I Type II
Y	N	Thyroid Problems
Y	N	Stroke
Y	N	Blood Transfusion
Y	N	Hemophilia/ Abnormal Bleeding
Y	N	Anemia
Y	N	HIV~AIDS
Y	N	Shingles
Y	N	Fever Blisters/ Cold Sores
Y	N	Drug/ Alcohol Abuse
Y	N	Hepatitis
Y	N	Venereal Diseases/ STD's
Y	N	Difficulty Breathing, Shortness of Breath
Y	N	Emphysema/ Bronchitis
Y	N	Asthma
Y	N	Osteoporosis
Y	N	Arthritis (Osteo)
Y	N	Arthritis (Rheumatoid)
Y	N	Cancer (Type)_____
Y	N	Chemotherapy
Y	N	Radiation Treatment (Date)_____
Y	N	Glaucoma or Cataracts (eye problems)
Y	N	Sinus Problems
Y	N	Tuberculosis (TB)
Y	N	Severe/ Frequent Headaches/Migraines
Y	N	Depression
Y	N	Anxiety
Y	N	ADHD/ ADD
Y	N	Psychiatric Problems
Y	N	Brain or Neural conditions
Y	N	Artificial Bones/ Joints (knee, hip etc)
Y	N	OSA/ Sleep Apnea
Y	N	Snoring
Y	N	CPAP Machine
Y	N	Kidney Problems
Y	N	Gout
Y	N	Epilepsy/Seizures/Fainting spells
Y	N	Ulcers
Y	N	Colitis
Y	N	HPV (Human Papilloma Virus)
Y	N	Hospitalized for any reason

Please list any pertinent information and serious medical conditions you have ever had and explain

Dental History:

Your current dental health is Good Fair Poor

Have you ever had serious/difficult problems associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? Yes No

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a **week** do you floss? _____ How many times a **day** do you brush? _____

Type of bristles? Hard Medium Soft

I acknowledge that the information given today is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence as outlined by HIPAA guidelines. I am aware it is my responsibility to inform the office immediately of any and all changes in my medical status. I also understand that every insurance policy is different and that I owe the total amount charged to my account regardless of insurance coverage. Any estimates of insurance coverage by Dr. Elias' office are done as a courtesy and are not binding and only my insurance company can make a final determination of benefits for my treatment.

X_____

Date:_____

Signed by patient or parent/guardian of minor patients