cooper moss
ADVANCED DENTISTRY

MEDICAL HISTORY

Name: _____ Date: _____
Last First M

Please list prescriptions, vitamins, and/or any herbal supplements you are currently taking: _____

_____

_____

Are you allergic to any antibiotics or other drugs? If so, please list: _____

_____

Circle if you have had any of the following:

Acid Reflux	Depression	Hepatitis	Rheumatic fever
Anaphylaxis	Diabetes	High blood pressure	Rheumatism
Arthritis	Eating Disorders	HIV/AIDS	Scarlet fever
Artificial heart valves	Endocarditis HX	HPV	Shingles
Artificial joints	Epilepsy	Kidney disease	Sinus problems
Asthma	Excessive bleeding	Liver disease	Sleep Apnea
Blood transfusion	Fainting	Mitral Valve Prolapse	Skin rash
Cancer	Glaucoma	Neck/Back Pain	Stroke
Chemical dependency	Head Injuries	No EPI	Thyroid disease
Chemotherapy	Heart Disease/Attack	Pacemaker	Tuberculosis
Circulatory problems	Heart Murmur	Psychiatric care	Tumors
Cold Sores	Heart Surgery	Radiation treatment	Ulcers
Dental Anxiety	Hemophilia	Respiratory disease	

If you are you *currently* experiencing or undergoing treatment for any of the conditions above, please specify. _____

_____

Any other serious health concerns or conditions? _____

Have you ever had to pre-medicate with antibiotics prior to dental treatment? Yes No. If yes, name of antibiotic prescribed to you: _____

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Physician's name: _____Phone Number: _____

Emergency contact and Phone Number: _____

Relationship: _____

DENTAL HISTORY

Former dentist: _____ Phone: _____

Do you have current x-rays? Yes No Date of last dental cleaning: _____

Homecare routine: How many times a day do you brush? _____ Floss? _____

Do you use an electric toothbrush or water pik? Yes No

Circle if you have had or currently have any of the following:

Braces or Invisalign	Sensitivity to hot/cold temperatures
Crown or Bridge treatment	Swelling or pain
Root Canal Treatment	Food collection between teeth
Gum treatment/grafting or surgery	Loose teeth or broken fillings
Wisdom teeth extracted	Sores or growths in mouth
Facial injury	Dental anxiety/fear
Jaw or muscle pain	Adverse reaction to anesthetic during treatment

Do you drink or use the following? If yes, please circle if intake is low, moderate or high.

Coffee-*Yes No*	Low	Moderate	High
Tea-*Yes No*	Low	Moderate	High
Soda Pop/Energy Drinks- *Yes No*	Low	Moderate	High
Sugar or Candy-*Yes No*	Low	Moderate	High
Chewing Gum- *Yes No*	Low	Moderate	High
Breath Mints-*Yes No*	Low	Moderate	High
Tobacco/Vaping Products-*Yes No*	Low	Moderate	High
Marijuana-*Yes No*	Low	Moderate	High
Alcohol-*Yes No*	Low	Moderate	High

How do you feel about the appearance of your teeth? _____

Are you interested in discussing Oral Conscious Sedation, Invisalign or Implants? YES NO

What is your primary dental concern? _____

_____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist. I also understand the use of anesthetic agents embodies a certain risk.

Signature_____Date_____