MEDICAL HISTORY

Name____________________ Date____________

Med Alert (for office use only)

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is kept confidential.

PLEASE CIRCLE IF YES:

YES Are you being treated for any medical condition presently OR in the past year?
____

YES Has there been any change in your general health in the past year?
____

When was your last medical checkup? ____________________________________

YES Have you been hospitalized in the past 2 years? _________________________

YES Do you take any prescription or non-prescription medications or remedies?
_______________ _______________ _______________ _______________
_______________ _______________ _______________ _______________

YES Do you have any allergic condition? (ex: asthma, skin rash, allergies to food or medicine, etc…) ____

YES Have you ever had an adverse or unusual reaction to any medicines or injections? ____

YES Have you been warned against taking any drug or medication? ____________

YES Have you been advised by your doctor to take antibiotics prior to dental treatment? ____

YES Do you have any blood or clotting disorders? ___________________________

YES Have you had any injury, surgery, or x-ray therapy to your head, jaws or face?
____

YES Have you traveled out of country in the past 14 days, OR been in contact with someone who has? If so, where? ____________________________________

Do you have or have you had any of the following? **PLEASE CIRCLE**

High blood pressure	Fainting/dizzy spells	Thyroid disease
Angina or chest pains	Epilepsy or seizures	Steroid/Prednisone therapy
Heart attack	Mental or Psychiatric illness	Malignant Hyperthermia
Coronary bypass/angioplasty	Eating disorder	Rheumatic Fever
Heart murmur	Drug/alcohol addiction	Kidney disease
Artificial valve	Reflux or GERD	Hepatitis or Liver disease
Heart pacemaker	Stomach ulcers	Sexually transmitted disease
Other heart problems	Inflammatory bowel disease	HIV/AIDS
Blood transfusions	Asthma/COPD	Cancer or tumor
Anemia	Tuberculosis	Radiation or chemotherapy
Stroke	Arthritis	Immune disease or therapy
Diabetes	Artificial joint	

Other: ____

YES Do you use nicotine or cannabis products (ex: cigarettes, vapes, etc…)?
If so, in what form and how much? ___________________________________

How many alcoholic beverages do you consume per week? __________________

Dental Care
DR. LINDSAY TUCKWOOD

DENTAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is kept confidential.

How frequently do you see a dentist? _______________ When was your last dental visit? ___________

Are any teeth sensitive to: ☐ cold ☐ heat ☐ sweet ☐ other? _________________________

Do you suffer from pain, swelling and bleeding in your gums? ☐ yes ☐ no

What dental treatments have you had in the past? ____

Do you grind or clench your teeth during the day or night? ☐ yes ☐ no

Does your jaw hurt, click, or pop when you open or close your mouth? ☐ yes ☐ no

Do you have any difficulty opening or closing you jaw? ☐ yes ☐ no

Have you experienced any sore spots or growths in your mouth? ☐ yes ☐ no

If so, where? ____

Do you suffer from dry mouth? ☐ yes ☐ no

Are you concerned about the appearance of your teeth, and if so what would you like to see changed? ____

How often do you brush? ____________ Floss? ____________ Other dental aids? ________________

Do you have any other concerns about your dental visit? _____________________________________

MEDICAL HISTORY UPDATE (for office use only)

Date	*Update or change?*	*Patient Inits*
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________
______	____________________________________	________

- I certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I will advise the dental office of any future changes to the information I have provided. I consent to my physician being contact if necessary, as this information may be required for my dental care.

Patient (or parent/guardian) signature: ___________________________________ Date: _________________________________

- I consent to a dental examination and to the performing of any dental procedures that my dentist **and I agree** to be necessary and advisable, including the use of local anesthetic as indicated. I will assume responsibility for fees associated with these procedures.

Patient (or parent/guardian) signature: ___________________________________ Date: _________________________________