LEGACY SMILES
Family Dental

MEDICAL HISTORY

Patient Full Name : _____

Patient Date of Birth: _____

Primary Care Physician: _____

Please check any that apply:

☐ Major Surgery: _____

☐ Serious head /Neck Injury: _____

☐ Joint Replacement: _____

☐ Artificial Heart Valve: _____

Medications of Dental Significance:

☐ Osteoporosis Medication (Fosamax, Boniva, Actonel, Reclast, Prolia, infusions, etc) _____

☐ Blood Thinner Medication (Coumadin, Eliquis, Xarelto, Pradaxa, etc)_____

☐ Steroid Medication (Prednisone, etc)_____

☐ Cancer Treatment (chemo, immunotherapy, radiation, etc_____

Do you currently follow a special diet? ☐ Yes ☐ No _____

Do you currently use tobacco/nicotine products? ☐ Yes ☐ No _____

Do you use controlled substances or recreational drugs that may affect dental treatment or anesthesia?

☐ Yes ☐ No

Medical Conditions

☐ Heart Disease

☐ High Blood Pressure

☐ Stroke

☐ Bleeding Disorder

☐ Blood Clots/DVT

☐ Diabetes

- Type 1___ or Type 2___
- Last A1C_____

☐ Thyroid Disease

☐ Chronic Lung Disease (Asthma/COPD/Emphysema)

- If asthma, do you carry a rescue inhaler & is it with you today?☐ Yes ☐ No

☐ Sleep Apnea

☐ Seizures

☐ HIV/Immunocompromised

☐ Autoimmune Disease

☐ Cancer

☐ Radiation to head or neck

☐ Liver Disease/Hepatitis

☐ Kidney Disease

- Dialysis? ☐ Yes ☐ No

☐ Glaucoma

☐ Gerd/Reflux

☐ Other: _____

Pregnancy & Women's Health

Pregnant? ☐ Yes ☐ No Due Date: ____/____/____ Trying to conceive? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No Oral contraceptives? ☐ Yes ☐ No

Allergies

☐ Aspirin	☐ Latex	☐ Metal
☐ Penicillin	☐ Local Anesthetic	☐ Acrylic
☐ Codeine	☐ Sulfa Drugs	☐ Other: _____

DENTAL HISTORY

Do you like your smile?	☐ Yes ☐ No
Are you currently in pain?	☐ Yes ☐ No
Bleeding gums?	☐ Yes ☐ No
Dry Mouth?	☐ Yes ☐ No
Mouth Breathing?	☐ Yes ☐ No
Jaw pain?	☐ Yes ☐ No
Snoring?	☐ Yes ☐ No
Teeth Grinding?	☐ Yes ☐ No
Sensitive Teeth?	☐ Yes ☐ No
Difficulty Getting Numb?	☐ Yes ☐ No
Dental Anxiety?	☐ Yes ☐ No
CPAP or Sleep Apnea?	☐ Yes ☐ No
Do you prefer fluoride alternatives?	☐ Yes ☐ No

Please list any additional medical conditions, medications or concerns not noted above_____

Antibiotic Premedication Question:

☐ I have been advised by a physician or dentist to take antibiotics before dental treatment.

Acknowledgement & Consent

☐ I confirm that the information provided is accurate to the best of my knowledge.

Patient Name (print) _____

Signature: _____ Date: ____/____/____