Taylor Brook Dental Associates
Medical History

Patient Name:_____ DOB:_____ Date:_____

Dental History ~ Please answer yes or no to the following questions:					
Do your gums bleed when you brush or floss?	Yes	No	Are your teeth sensitive to cold, hot, ?	Yes	No
Does food or floss catch between your teeth?	Yes	No	Have you had any periodontal (gum) treatments?	Yes	No
Are you currently experiencing dental pain?	Yes	No	Have you ever had orthodontic (braces) work?	Yes	No
Do you have any clicking, popping or discomfort?	Yes	No	Is your mouth dry?	Yes	No
Have you ever had a serious injury to your mouth?	Yes	No	Do you brux or grind your teeth?	Yes	No
Do you have sores or ulcers in your mouth?	Yes	No	Do you wear dentures or partials?	Yes	No
Do you have any earaches or neck pain?	Yes	No	Do you have high anxiety or fear of receiving dental treatments?	Yes	No
If you had a magic wand, what would you change about your smile?					
Are you interested in straightening your teeth?	Yes	No	Are you interested in whitening your smile?	Yes	No
Are you interested in replacing missing teeth?	Yes	No			

Medical History ~ Are you taking any of the following:					
Antibiotics or sulfa drugs	Yes	No	Anticoagulants (blood thinners)	Yes	No
Medicine for high blood pressure	Yes	No	Cortisone (steroids)	Yes	No
Tranquilizers	Yes	No	Antihistamines	Yes	No
Aspirin	Yes	No	Ibuprofen/Tylenol	Yes	No
Insulin, Metformin, Glucophage, Orinase	Yes	No	Digitalis	Yes	No
Nitroglycerin	Yes	No	Viagra or similar	Yes	No
Phen-Fen/Redux	Yes	No			
Other medications, vitamins, natural supplements, etc.(please list):					

Medical History ~ Other			
Are you under a physician's care now?	Yes	No	If yes, his/her name and phone number:
Have you ever been hospitalized or had a major surgical procedure?	Yes	No	If yes please expand:
Have there been any changes in your general health within the past year?	Yes	No	If yes please expand:
Have you had a total joint (hip, knee, elbow, shoulder) replacement? When? Complications?	Yes	No	If yes please expand:
Are you or have you ever been advised to take antibiotics prior to a dental procedure?	Yes	No	If yes please expand:
Do you take: Fosamax, Boniva, Actonel or medications with bisphosphonates?	Yes	No	If yes please expand:
Since 2001, were you treated with IV bisphosphonates (Aredia or Zometa)?	Yes	No	If yes please expand:
Do you use tobacco (smoking, snuff, bidis)?	Yes	No	If yes please expand:

Allergies ~ Are you allergic to any of the following:

☐Aspirin ☐Metal ☐Penicillin ☐Latex ☐Codeine ☐Sulfa Drugs ☐Acrylic ☐Local Anesthetics ☐Other (please list):

Women are you: ☐Pregnant/Trying to get pregnant? ☐Nursing ☐Taking Oral Contraceptives?

Medical History continued on back (please flip over)

Medical History ~ Current/Past: Do you have, or have you had, any of the following? Circle Yes for those that apply to you.											
AIDS/HIV Positive	Yes	No	Cold sores/Fever Blisters	Yes	No	Hepatitis A	Yes	No	Parathyroid Disease	Yes	No
Alzheimer's Disease	Yes	No	Congenital Heart Disorder	Yes	No	Hepatitis B or C	Yes	No	Psychiatric Care	Yes	No
Anaphylaxis	Yes	No	Convulsions	Yes	No	Herpes	Yes	No	Radiation Treatments	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	High Blood Pressure	Yes	No	Renal Dialysis	Yes	No
Angina	Yes	No	Drug Addiction	Yes	No	High Cholesterol	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Easily Winded	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Heart Valve	Yes	No	Emphysema	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Artificial Joint	Yes	No	Epilepsy or Seizures	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Excessive Bleeding	Yes	No	Kidney Problems	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	Excessive Thirst	Yes	No	Leukemia	Yes	No	Thyroid Disease	Yes	No
Blood transfusion	Yes	No	Fainting Spells/Dizziness	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Breathing Problems	Yes	No	Heart Attack/Failure	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Bruise Easily	Yes	No	Heart Murmur	Yes	No	Lung Disease	Yes	No	Tumors or Growths	Yes	No
Cancer	Yes	No	Heart Pacemaker	Yes	No	Mitral Valve Prolapse	Yes	No	Ulcers	Yes	No
Chemotherapy	Yes	No	Heart Trouble/Disease	Yes	No	Osteoporosis	Yes	No			
Chest Pains	Yes	No	Hemophilia	Yes	No	Pain in Jaw Joints	Yes	No			
Have you ever had any serious illness not listed?							Yes	No	If Yes please list:		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent or Guardian Date