middleton smiles
Family Dentistry

Health History

Patient Name (First, MI, Last)____

Date of Birth:______________________________________ Preferred Phone#: _____________________________

Medical History:

Name and Location of Medical Doctor:

Please Circle all that Apply:

Artificial Joints/Valves	Heart Disease	Diabetes - Type I or II	Cancer	Thyroid Disease
COVID-19	Heart Surgery	Kidney Problems	Radiation Treatment	Dementia
Hepatitis	Heart Murmur	Liver Disease	Transplant	Parkinsons Disease
Lung Disease/COPD	Pacemaker	Arthritis	Bone Disease	Drink Alcohol often
Stroke	Blood Transfusion	Seizures/Epilepsy	Osteoporosis	Psychiatric Care
Tuberculosis/TB	Blood Disorder	Sinus Problems	Frequent Headaches	Currently Pregnant
HIV/AIDS	Excessive Bleeding	Asthma	Excessive Napping	Sleep Apnea/CPAP
High Cholesterol	High Blood Pressure	Cold Sores	Often Fatigued	History of Snoring

Please give details of circled conditions above or list other conditions not listed: ____________________________________

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Allergies/Medications:

Are you allergic to any medications? Yes No Please list: ____

____

Do you take a daily Aspirin? Yes No

Please list prescription medications you are currently taking: *See attached list

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Do you require Pre-Medication for dental procedures? Yes No

Have you ever taken prescription medication for BONE CONDITIONS? (Boniva, Fasamax, Actonel, Reclast or Generic):

Yes No If yes, Please list: ____

Oral History:

When was your last Dental Cleaning:______________________________

Have you ever been treated for periodontal (gum) disease? Y N

Have you ever had any issues with local anesthetic? Y N If yes, please explain:____________

____

How happy are you with your smile (1 not happy -10 happy)? ________

Please circle any conditions that apply to you:

Pain in Jaw (TMJ)	Teeth Grinding/Clenching	Smoke/Use Tobacco Products	Mouth Sores
Sensitive Teeth	Broken/Loose Teeth	Difficulty Swallowing	Swollen/Bleeding Gums

Have you ever had Orthodontic Treatment? Y N

Are you interested learning about options for straightening your teeth? Y N

- I verify the information I provided is correct & will update Middleton Smiles of any changes to my medical history.
- I understand that dental procedures and anesthetics carry risk of temporary or permanent numbness.
- I authorize Middleton Smiles to perform dental services that are needed during diagnosis and treatment.

Signature: ____ Date: ______________________

Relationship to patient: ____________________________________

Updated Health History: Pt Initial:_______________________ Date:____________

Office Notes: ☐ Pre-Med B/P:______________