middleton smiles
Family Dentistry

Health History

Patient Name (First, MI, Last)_____
Date of Birth:_____ Preferred Phone#: _____

Preferred Pharmacy:_____ Phone #_____
Street Location & City_____

Medical History:

Name and Location of Medical Doctor:_____

Please Circle all that Apply:

Artificial Joints/Valve	Heart Disease	Cancer	Frequent Headaches	Pain in Jaw (TMJ)
Hepatitis (Type:___)	Heart Surgery	Radiation Treatment	Excessive Napping	Sjogren's Syndrome
Lung Disease/COPD	Heart Murmur	Alzheimer's Disease	Often Fatigued	Sleep Apnea/CPAP
Stroke	Pacemaker	Dementia	Drink Alcohol often	History of Snoring
Tuberculosis/TB	Blood Transfusion	Parkinson's Disease	Psychiatric Care	Clenching/Grinding
HIV/AIDS	Blood Disorder	Bone Disease	Smoke/Vape/Tobacco Use	Broken/Loose Teeth
Diabetes - Type I or II	High Cholesterol	Osteoporosis	Dry Mouth	Difficulty Swallowing
Thyroid Disease	High Blood Pressure	Arthritis	Sinus Problems	Swollen/Bleeding Gums
Kidney Problems	Transplant	Seizures/Epilepsy	Mouth/Cold Sores	Sensitive Teeth
Liver Disease	Excessive Bleeding	Asthma	Bad Breath	Currently Pregnant

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

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: *Please Check box if list is attached ☐

_____

_____

_____

Do you require Pre-Medication for dental procedures (due to artificial joints or pacemaker)? Yes No

Have you ever taken Prescribed Medications for BONE CONDITIONS or Osteoporosis such as Boniva, Fosamax, Actonel, Prolia, Reclast or Generic (Bisphosphonates)?: Yes No If yes, Please list: _____

NEW PATIENTS – Oral History:

Date of Last Dental visit (other than in our office): _____Last Xrays:_____

Have you ever been treated for periodontal (gum) disease? Y N If Yes, have you ever had Scaling and Root Planing or a "Deep Cleaning" Y N When & Where?_____

Do you have any implants? Y N If Yes, Office they were placed in and when? _____
_____

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

Have you ever had Orthodontic Treatment? Y N Where:_____

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: _____

Office Use only: Updated Health History: Pt Initial:_____ Date:_____
Office Notes: ☐ Pre-Med B/P:_____