middleton smiles
Family Dentistry

Health History

Patient Name (First, MI, Last) _____Date of Birth _____
Email Address: _____ Preferred Phone#: _____
Preferred Pharmacy: _____ Phone #_____
Street Location & City_____

Medical History:

Name and Location of Medical Doctor:_____

Please Circle all that Apply:

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