Sutter Terrace Dental Group

Account #_____

Confidential Dental & Medical History

Patient Name: _____ Date of Birth_____
Last First MI ☐ Male ☐ Female

Previous Dentist: _____ Date of Last Dental Visit: _____

Please circle Yes or No to each of the following questions or conditions:

Yes No Do you have a specific dental problem? Please describe: _____
Yes No Do you think you have decay or gum disease? _____
Yes No Do your gums bleed? Describe: _____
Yes No Do you use tobacco? Describe: _____
Yes No Do you dislike the appearance or color of your teeth? Describe_____
Yes No Have you ever had orthodontic treatment (tooth straightening)? _____
Yes No Do you ever clench or grind your teeth? Describe _____
Yes No Do you suffer from (experience) a dry mouth? _____
Yes No Do you experience clicking, popping or discomfort in your jaw joints (TMJ)? Describe _____
_____
Yes No Are you nervous or anxious about having dental treatment? _____
Yes No Have you ever had a bad dental experience? Describe _____
Yes No Are you interested in using nitrous oxide gas? _____
How do you take care of your teeth and gums? Describe _____

Do you or have you ever had:

Yes No Congenital heart conditions	Yes No HIV positive (AIDS)	Yes No Phen-Fen/ Redux use	Yes No Cancer
Yes No Heart pacemaker	Yes No Bruise easily	Yes No Mental health disorder	Yes No Radiation treatments
Yes No Heart surgery/stents	Yes No Hypoglycemia	Yes No Alzheimer's/Dementia	Yes No Chemotherapy
Yes No Artificial heart valve	Yes No Shortness of breath	Yes No Drug/alcohol addiction	Yes No Artificial joint/knee/hip
Yes No Stroke	Yes No Fainting or dizziness	Yes No Anxiety/panic disorder	Yes No Lupus
Yes No High blood pressure	Yes No Allergies	Yes No Cold sores	Yes No Arthritis/gout
Yes No Low blood pressure	Yes No Asthma	Yes No Diabetes	Yes No Rheumatism
Yes No Anemia	Yes No Sinus conditions	Yes No Kidney disease	Yes No Glaucoma
Yes No Blood transfusion	Yes No Emphysema/COPD	Yes No Swelling of hands/ feet	Yes No Cortisone medication
Yes No Hemophilia/ Uncontrolled bleeding	Yes No Frequent cough	Yes No Hepatitis	Yes No Thyroid disease
	Yes No Tuberculosis	Yes No Jaundice	Yes No Para-thyroid disease
	Yes No Recent weight loss	Yes No Epilepsy or seizures	Yes No Osteoporosis

Name of Physician: _____ Phone:(____)_____
Are you presently under the care of your physician? ☐ Yes ☐ No If Yes, please explain: _____
_____
Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No If Yes, please explain:
_____
Please list all prescription medication(s) you are taking: _____
Do you or have you taken bisphosphonates (i.e., Fosamax, Boniva) for cancer treatment or osteoporosis?_____
Do you use "recreational or street" drugs? ☐ Yes ☐ No_____
Are you allergic to any medications or substances? ☐ Yes ☐ No If Yes, please list: _____
Have you ever experienced a reaction to latex gloves or latex products? ☐ Yes ☐ No_____
Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain _____
_____
Do you have any health conditions that need further clarification? ☐ Yes ☐ No_____
Do you wish to speak to the dentist privately about any problem or condition? ☐ Yes ☐ No
Female patients:
Are you pregnant? ☐ Yes ☐ No If Yes, due date?_____
Are you taking birth control pills or hormone replacement therapy? ☐ Yes ☐ No_____

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I have a change in my health, medical conditions or medications I will inform the doctor(s) and/or dental hygienist(s). I have received a copy of *The Facts About Fillings* as required by the Dental Board of California.

Signature of patient, parent or guardian	**Relationship (other than self)**	**Date**	**Doctor's Signature/Date**

Date	*Changes to Health History*	*Patient Signature*	*Hygienist/Doctor's Signature*