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. Do you or have you ever had:

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 use "recreational or street" drugs? _____
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 Have you ever had a bad dental experience or any complications following dental treatment? _____
_____
Yes No Are you nervous or anxious about having dental treatment? _____
Yes No Are you interested in using nitrous oxide gas? _____
How do you take care of your teeth and gums? Describe _____

Please circle Yes or No to each of the following. Do you or have you ever had:

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

Yes No Are you allergic to any medications? If Yes, please list: _____ _____

Please list all prescription medication(s) you are taking: _____ _____ _____

_____ _____ _____ _____ _____

Name of Physician: _____ Phone: (____) _____
Yes No Are you presently under the care of your physician? If Yes, please explain: _____
_____
Yes No Have you been admitted to a hospital or needed emergency care during the past two years? If Yes, please explain:
_____
Yes No Do you or have you taken bisphosphonates (i.e., Fosamax, Boniva) for cancer treatment or osteoporosis? _____
Yes No 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? _____

Female patients:

Yes No Are you pregnant? If Yes, due date? _____
Yes No Are you taking birth control pills or hormone replacement therapy? _____

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/Hygienist'sSignature/Date**

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