DENTAL CLINIQUE

Dental & Medical History Update

Patient name: _____ Date: _____ Date of birth: _____

Email: _____ Phone: _____

Address: _____

Emergency contacts

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Dental health questions

Please check one answer for each question. If you answer Yes, provide details when helpful.

Question	Response
Do your gums bleed when you brush or floss?	☐ Yes ☐ No ☐ Unsure
Are your teeth sensitive to hot, cold, sweets, or biting pressure?	☐ Yes ☐ No ☐ Unsure
Does food get caught between your teeth?	☐ Yes ☐ No ☐ Unsure
Do you experience dry mouth?	☐ Yes ☐ No ☐ Unsure
Do you wear a denture or partial denture?	☐ Yes ☐ No ☐ Unsure
Have you had a serious head injury within the last 6 months?	☐ Yes ☐ No ☐ Unsure
Are you interested in learning about options to improve your smile?	☐ Yes ☐ No ☐ Unsure
Do you know anyone who is looking for a dentist?	☐ Yes ☐ No ☐ Unsure

Dental concerns or details: _____

Medical history questions

Please answer every question. Accurate information helps us provide safe dental care.

Question	Response
Has your health changed since your last visit?	☐ Yes ☐ No ☐ Unsure
Have you had any hospital stays, surgeries, or emergency visits since your last visit?	☐ Yes ☐ No ☐ Unsure
IMPORTANT: Have you been told to take antibiotics or other premedication before dental appointments?	☐ Yes ☐ No ☐ Unsure
Have you ever taken Fosamax, Actonel, Zometa, or other medications for osteoporosis or cancer-related bone disease?	☐ Yes ☐ No ☐ Unsure
Do you take a blood thinner or antiplatelet medication, including baby aspirin?	☐ Yes ☐ No ☐ Unsure
Do you have high blood pressure?	☐ Yes ☐ No ☐ Unsure
Do you have diabetes?	☐ Yes ☐ No ☐ Unsure
Do you currently use tobacco or nicotine products?	☐ Yes ☐ No ☐ Unsure
Have you used tobacco or nicotine products in the past?	☐ Yes ☐ No ☐ Unsure
Do you drink alcohol?	☐ Yes ☐ No ☐ Unsure
Do you have cardiovascular or heart disease?	☐ Yes ☐ No ☐ Unsure
Do you snore, or has someone told you that you snore?	☐ Yes ☐ No ☐ Unsure
Do you wake up during the night?	☐ Yes ☐ No ☐ Unsure
Have you ever had a sleep study?	☐ Yes ☐ No ☐ Unsure

If diabetes: ☐ Type 1 ☐ Type 2 ☐ Other / unsure Latest A1c (if known): _____

If you previously used tobacco: years of use: _____ Date quit: _____

Alcohol use (frequency/amount, if applicable): _____

Premedication (medication, reason, prescriber): _____

Health changes, hospital stays, or other Yes answers (include dates): _____

_____

Allergies — please list all

☐ No known allergies ☐ Allergies listed below ☐ Unsure

Medication, food, latex, or other allergy	Reaction

Current medications — please list ALL

Include prescriptions, over-the-counter drugs, vitamins, supplements, hormones, and as-needed medicines. Attach a list if needed.

Medication / supplement	Dose (if known)	Frequency

☐ I have attached my current medication list. ☐ I do not currently take any medications or supplements.

Patient confirmation

I have reviewed my answers and believe they are complete and accurate to the best of my knowledge. I will inform the dental team of changes.

Patient / guardian signature: _____ Date: _____

Reviewed by dental team: _____ Date: _____