Time 12:00 PM | Bear Creek Dental | Date 10/1/2019

Bear Creek Dental Medical/ Dental History

Patient Name: Birth Date: Date Created:

About You Medically

Question	Answer	
Are you under a physician's care now? If so name of physician and number	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Are taking any non-prescription (over the counter) medication?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco or vaping products?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No
Hepatitis B	◯ Yes ◯ No	Hepatitis C	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Herpes/Cold Sores	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Chest Pain	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Chemo/Radiation Therapy	◯ Yes ◯ No	Thyroid/Parathyroid	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Ulcers/Stomach/Intestinal Disease	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Cortisone Medication	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

About Your Dental History

Your current dental health is?

☐ Good ☐ Fair ☐ Poor

Question	Answer	
Do your gums bleed?	◯ Yes ◯ No	
Do you require antibiotics before dental treatment?	◯ Yes ◯ No	If yes
Are you currently in pain?	◯ Yes ◯ No	If yes
Have you ever had a serious/difficult problem associated with any previous dental work?	◯ Yes ◯ No	If yes
Have you ever had periodontal treatment? If so where?	◯ Yes ◯ No	If yes
Do you have jaw pain?	◯ Yes ◯ No	If yes
Ae your teeth sensitive to hot, cold, or anything else?	◯ Yes ◯ No	

Do you like your smile?

How many times a week do you floss?

How many times a day do you brush?

What type of toothbrush do you prefer?

☐ Manual ☐ Electric

What type of bristles does your toothbrush have?

☐ Ultra Soft ☐ Soft ☐ Medium ☐ Hard

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:___________