WEST ASHLEY
FAMILY DENTISTRY

Patient Medical and Dental History Form

Patient Name _____ Birthdate _____ Today's Date _____

Dental History

Former Dentist _____ City _____ State _____ Date of Last Visit _____

Do You Notice ☐ Grinding teeth ☐ Clicking or popping of the jaw ☐ Jaw pain or tiredness

Select All That Apply ☐ Bad breath ☐ Dry mouth ☐ Mouth breathing ☐ Bleeding gums ☐ Swollen or tender gums
☐ Blisters on mouth ☐ Burning sensation on tongue
☐ Loose or broken fillings ☐ Food stuck between teeth ☐ Lip or cheek biting ☐ Fingernail biting

Medical History

Physician's name _____ Date of last visit _____
Pharmacy name _____ Pharmacy phone _____

Select Any That Apply
☐ Artificial Joints ☐ Artificial heart valve ☐ Previous bacterial endocarditis ☐ Congenital heart defect
☐ High blood pressure ☐ Low blood pressure ☐ Pacemaker
☐ Asthma ☐ Cough, persistant ☐ Emphysema ☐ Shortness of breath ☐ Respiratory disease
☐ AIDS/HIV ☐ Anemia ☐ Abnormal bleeding with surgery or extractions ☐ Blood disease
☐ Diabetes ☐ Circulatory Problems ☐ Hepatitis (select type) _____ ☐ Jaundice
☐ Cancer ☐ Chemotherapy/immunosuppressive ☐ Radiation therapy ☐ Osteoporosis
☐ Autoimmune disorder ☐ Seizures/epilepsy ☐ Fainting/dizziness ☐ Glaucoma
☐ Headaches ☐ Kidney disease ☐ Liver disease ☐ Arthritis/Rheumatism ☐ Skin rash
☐ Nervous system disorder ☐ Psychiatric care ☐ ADD/ADHD ☐ Eating disorder
☐ Sleep disorder (apnea, snoring, insomnia, restless sleep) ☐ GI ulcer ☐ Special diet
☐ Stroke (how long ago) _____ ☐ Tonsillitis ☐ Sinus trouble ☐ Thyroid disorder
☐ STD/STI/HPV ☐ Tuberculosis

Please describe any affirmative responses below

Do you have an allergy to ☐ Local Anesthetic ☐ Penicillin ☐ Latex ☐ Other _____

Are you pregnant? ○ No ○ Yes Due date _____

Are you nursing? ○ No ○ Yes

Taking birth control? ○ No ○ Yes

Please list all medications you are taking, dose, and what you are taking them for:

Please list any other conditions you feel we should know about or any specific questions or concerns you may have about your visit.

Are you experiencing ☐ Fever ☐ Shortness of breath ☐ Dry cough ☐ Runny nose ☐ Sore throat ☐ Loss of taste/smell

Within the last 14 days have you travelled: ☐ Within the US ☐ Outside the US If yes to either, where? _____

Have you or anyone you have been in contact with been diagnosed with COVID-19? ○ Yes ○ No

By typing your name here you certify that all information on this form is correct to the best of your knowledge.

TYPE PATIENT/GUARDIAN NAME HERE