All Smiles Dental Care

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Medical History

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Allergies - Seasonal
- ☐ Allergy - Medication
- ☐ Allergy - Other
- ☐ Allergy-Anesthestic
- ☐ Anaphylaxis
- ☐ Arthiritis/Gout
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease/Anemia
- ☐ Breathing Problems
- ☐ Cancer - History
- ☐ Cancer - Present
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores
- ☐ Cortisone Medicine
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Epilepsy/Seizures
- ☐ Esophogeal Problems
- ☐ Gastric Problems
- ☐ Glaucoma
- ☐ Head/Neck Injury
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High/Low Blood Press
- ☐ High/Low Cholesterol
- ☐ HIV/AIDS
- ☐ Intestinal Disorder
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung/Resp Disease
- ☐ Nervous Disorder
- ☐ NONE
- ☐ Oral Contraceptives
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnant/Nursing
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disorder
- ☐ Venereal Disease
- ☐ Weight Disorder

- ☐ Do you use tobacco (cigarettes, vape, chew)?
- ☐ Do you have neck, shoulder or back pain?
- ☐ Do you snore and/or wake up tired?
- ☐ Have you ever had a head or neck injury?
- ☐ Are you restless or have attention concerns?
- ☐ Has your jaw ever locked open or closed?

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

Name of your physician and date of your last routine visit. Describe any current, recent or upcoming medical treatment or surgeries that may possibly affect your dental treatment:

_____

_____

List all medications, supplements and vitamins that you currently take or have taken in the last 2 years.

_____

_____

☐ *** By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: _____