MILLER FAMILY DENTAL

Medical History

Patient Name:	Patient DOB:
Physician's Name:	Date of Last Visit:
Are you currently under the care of a physician? ☐ Yes ☐ No If yes, please explain:	
Have you had any serious illnesses, operations or been hospitalized in the last five years? ☐ Yes ☐ No If yes, please describe:	
Do you have any artificial joints (knee, hip, shoulder etc.)? ☐ Yes ☐ No Year(s): _____ If yes, please explain:	
Have you had a heart valve replacement or heart surgery? ☐ Yes ☐ No Year(s): _____ If yes, please explain:	
Do you require premedication or antibiotics prior to dental treatment? ☐ Yes ☐ No If yes, please explain:	
Do you have any allergies (foods, medications, latex, seasonal, anesthetics, metals etc.)? ☐ Yes ☐ No If yes, please explain:	
Have you ever taken any bisphosphonate drugs (oral or IV) like Fosamax or Boniva? ☐ Yes ☐ No If yes, please explain:	
Do you take blood thinners like Coumadin or Warfarin? ☐ Yes ☐ No If yes, please explain:	
Have you ever taken Fen Phen or Redux? ☐ Yes ☐ No If yes, please explain:	
Have you ever had chemotherapy or radiation treatment? ☐ Yes ☐ No Year(s): _____ If yes, please explain:	
How would you rate your overall health? (circle one) Excellent Good Fair Poor	
WOMEN: Are you currently pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control of any kind? ☐ Yes ☐ No	

Dental and Social History

Reason for today's dental visit: _____

Date of Last Dental Visit:	Were x-rays taken during that visit? ☐ Yes ☐ No
Are you currently experiencing dental pain or discomfort? ☐ Yes ☐ No	If yes, please explain:

Patient Initials _____

Do you have dental anxiety? ☐ Yes ☐ No	If yes, please explain:
Have you ever had periodontal (gum) treatments? ☐ Yes ☐ No	If yes, please explain:
Do you use tobacco or vape products? ☐ Yes ☐ No	If yes, type and amount:
Do you drink alcohol? ☐ Yes ☐ No	If yes, how much per week?
Do you use illegal drugs? ☐ Yes ☐ No	If yes, please explain:
Do you use marijuana products? ☐ Yes ☐ No	If yes, please explain:

Check if you have or have had problems with any of the following:

YES	NO		YES	NO	
_____	_____	Bad breath	_____	_____	Broken fillings
_____	_____	Grinding teeth	_____	_____	Sensitivity to sweets
_____	_____	Clenching teeth	_____	_____	Clicking or popping jaw
_____	_____	Bleeding gums	_____	_____	Sensitivity when biting
_____	_____	Loose teeth	_____	_____	Sores/growths in mouth
_____	_____	Broken teeth	_____	_____	Sensitivity to hot/cold

Check if you have or have had any of the following medical conditions:

YES	NO		YES	NO	
_____	_____	Anemia	_____	_____	Hepatitis A, B or C
_____	_____	Anxiety	_____	_____	Herpes/Cold Sores
_____	_____	Arthritis	_____	_____	High Blood Pressure
_____	_____	Asthma	_____	_____	HIV/AIDS
_____	_____	Back Problems	_____	_____	Jaw Pain
_____	_____	Blood Disease	_____	_____	Kidney Disease
_____	_____	Brain Injury	_____	_____	Liver Disease
_____	_____	Cancer	_____	_____	Lung Disorders
_____	_____	Chemotherapy	_____	_____	Lupus
_____	_____	Circulatory Problems	_____	_____	Low Blood Pressure
_____	_____	Congenital Heart Disease	_____	_____	Mental Health Disorder
_____	_____	Cortisone Treatments	_____	_____	Mitral Valve Prolapse
_____	_____	Depression	_____	_____	Neurologic Disorder
_____	_____	Diabetes	_____	_____	Osteoporosis
_____	_____	Emphysema	_____	_____	Pacemaker
_____	_____	Endocarditis	_____	_____	Radiation Treatment
_____	_____	Epilepsy	_____	_____	Respiratory Disease
_____	_____	Fainting	_____	_____	Rheumatic Fever
_____	_____	Glaucoma	_____	_____	Shortness of Breath
_____	_____	Hemophilia	_____	_____	Stroke
_____	_____	Heart Murmur	_____	_____	Thyroid Disease
_____	_____	Heart Conditions/Disease	_____	_____	Tuberculosis
_____	_____	Heart Attack	_____	_____	Ulcers

Patient Initials _____

Please explain any box checked 'yes': _____
_____
_____
_____

Other medical conditions not listed above: _____
_____

Please list all medications you are currently taking.

Name of Medication	Dose	Frequency	Reason

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold Miller Family Dental or any member or staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____
(If minor, parent/guardian signature required)

Print Name: _____

Date: _____