PEAK
FAMILY DENTISTRY & ORTHODONTICS

Medical History

Patient Name _____ DOB_____

Are you having pain or discomfort at this time? *Yes* *No* If yes, please explain: _____

Last Dentist Visit _____ Date of Last Cleaning _____

Are you under a physician's care now? *Yes* *No* If yes, please explain: _____

Have you ever had any problems with past dental treatment? *Yes* *No* If yes, please explain: _____

Have you been hospitalized during the past two years? *Yes* *No* If yes, please explain: _____

Have you ever had a serious head or neck injury? *Yes* *No* If yes, please explain: _____

Are you currently taking any medications? *Yes* *No* If yes, please list all medications you are currently taking: _____

Are you allergic to (i.e., itching, rash, swelling) or made sick by penicillin, aspirin, codeine, or any drugs or medications? *Yes* *No*

If yes, please explain: _____

Have you ever taken Fosamax, Bonita, Actonel or any other medications containing bisphosphonates? *Yes* *No*

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

Artificial Heart Valve	*Yes*	*No*	Anemia	*Yes*	*No*	Allergies or Hives	*Yes*	*No*
Heart Attack/ Surgery	*Yes*	*No*	Stroke	*Yes*	*No*	Diabetes	*Yes*	*No*
Heart Murmur	*Yes*	*No*	Kidney Trouble	*Yes*	*No*	Jaundice	*Yes*	*No*
High Blood Pressure	*Yes*	*No*	Ulcers	*Yes*	*No*	Arthritis	*Yes*	*No*
AIDS/HIV +	*Yes*	*No*	Liver Problems	*Yes*	*No*	Tobacco	*Yes*	*No*
Angina Pectoris	*Yes*	*No*	Lung disease	*Yes*	*No*	Epilepsy or Seizures	*Yes*	*No*
Rheumatic Fever	*Yes*	*No*	Thyroid Disease	*Yes*	*No*	Fainting/Dizzy Spells	*Yes*	*No*
Bleeding Problems	*Yes*	*No*	Emphysema	*Yes*	*No*	Sleep Apnea	*Yes*	*No*
Low Blood Pressure	*Yes*	*No*	Cold Sores	*Yes*	*No*	Chemotherapy	*Yes*	*No*
Heart Pacemaker	*Yes*	*No*	Tuberculosis (TB)	*Yes*	*No*	Radiation Treatment	*Yes*	*No*
Hemophilia	*Yes*	*No*	Glaucoma	*Yes*	*No*	Cancer	*Yes*	*No*
Joint Replacement	*Yes*	*No*	Cosmetic Surgery	*Yes*	*No*	Hepatitis	*Yes*	*No*
Asthma	*Yes*	*No*	Sinus Trouble	*Yes*	*No*	Venereal Disease	*Yes*	*No*
Nervousness/ Anxiety	*Yes*	*No*	Psychiatric Treatment	*Yes*	*No*	Acid Reflux/ GERD	*Yes*	*No*

Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain, or locking open? Yes No

If yes, please explain:_____

(Women) Are you pregnant now? Yes No If yes, how many months? _____ Are you nursing? Yes No

Do your gums bleed easily? Yes No

Are your teeth sensitive to hot or cold? Yes No

Would you like your teeth whiter? Yes No

Is there anything you would like to change about your smile? Yes No

If yes, please explain: _____

Do you have any disease, conditions, or problems not listed above?_____

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 _____Date _____