Bridgman Family Dental Care
Medical History

Legal Name ______________________________ Preferred Name ______________________________

Birthdate ____________________ Gender: Male ______ Female _______

Have you **ever had** any of the following:

(♦-may need antibiotic premedication)

- ☐ ♦Artificial Joint replacement
  Hip knee other Date of surgery____________
- ☐ ♦Artificial Heart Valve
- ☐ ♦Previous Bacterial Endocarditis
- ☐ Heart Failure
- ☐ Heart Disease or Heart Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Heart Surgery/Stent
- ☐ Heart Pacemaker or Defibulator
- ☐ Congenital Heart Lesions
- ☐ Mitral Valve Prolapse
- ☐ Shortness of breath walking up stairs
- ☐ Swollen ankles during the day
- ☐ Stroke/Family history of stroke
- ☐ Leukemia/Anemia/Sickle cell anemia
- ☐ Cancer/Tumor/Chemotherapy Type ____________ Year _______
- ☐ Diabetes; HbA1c______
- ☐ Thyroid condition
- ☐ Currently smoke; how many cigarettes per day _______
- ☐ Currently vape or use an e-cigarette ______________________
- ☐ Currently use nicotine in any form
- ☐ Currently using marijuana or any form of a controlled substance
- ☐ Sleep apnea/snoring
- ☐ Osteoporosis or osteopenia
- ☐ Taken: Fosamax/Actonel/Boniva/Bisphosphonates
- ☐ Rheumatoid arthritis
- ☐ Systemic Lupus Erythematosis
- ☐ Migraine headaches
- ☐ Restless leg syndrome
- ☐ Stress/anxiety/depression
- ☐ Post-traumatic stress disorder
- ☐ Epilepsy or Seizures
- ☐ Fainting or dizzy spells
- ☐ Hepatitis A, B, or C
- ☐ Liver disease/Yellow jaundice
- ☐ Ever taken Phen Phen
- ☐ Mononucleosis
- ☐ Hemophilia
- ☐ Blood transfusion
- ☐ Bruise easily
- ☐ Asthma
- ☐ Emphysema
- ☐ Persistent cough
- ☐ Wake up short of breath
- ☐ Tuberculosis (TB)
- ☐ Lost/gained more than 10 lbs quickly
- ☐ Special diet
- ☐ Kidney trouble
- ☐ Ulcers
- ☐ Frequent headaches
- ☐ Prolonged unexplained fever
- ☐ Prolonged infection that was long in clearing up
- ☐ Prolonged unexplained sore throat
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ GERD
- ☐ Auto immune conditions
- ☐ Allergic reaction/hives
- ☐ Arthritis
- ☐ Cortisone medicine
- ☐ Glaucoma
- ☐ AIDS/HIV
- ☐ Physically/mentally handicapped
- ☐ Substance abuse (drug, alcohol)
- ☐ Sexually transmitted disease
- ☐ Nervousness
- ☐ Psychiatric treatment
- ☐ Hearing impaired
- ☐ Alzheimer's or dementia
- ☐ Requires a caregiver
- ☐ Other: ______________________________

Physician's Name ______________________________ Date of last physical __________

City ______________________________ Phone number ________________

Have you been admitted to the hospital during the past two years? ☐Yes ☐ No

Have you been told by a doctor to take antibiotics prior to dental appointments? ☐Yes ☐ No

Women – Are you pregnant? ☐Yes ☐ No If yes, what month __________

Do you use birth control medication of any kind ☐Yes ☐ No

Please list all medications you are currently taking (include over-the-counter medications and herbal supplements)

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

CONTINUED ON THE OTHER SIDE

Have you ever been allergic to any of the following:

☐ Latex/metals/plastics	☐ Codeine	☐ Tetracycline
☐ Chlorhexidine	☐ Percodan	☐ Sulfa
☐ Novocaine or Xylocaine	☐ Valium	☐ Penicillin/Ampicillin/Amoxicillin
☐ Aspirin	☐ Nembutal/Seconal (sleeping pills)	☐ Ceclor
☐ Demerol	☐ Erythromycin	

Are you aware of being **allergic** to **ANY OTHER** medication or substances?

If yes, please list: ____

Dental History

☐ Gums bleed when brushing or flossing	☐ Food traps between teeth	☐ Piercing (face, lip, tongue)
☐ Sensitive gums	☐ Loose teeth	☐ Dental implant
☐ Bad breath/bad taste in mouth	☐ Difficult to open mouth wide	☐ Gag easily
☐ Dry mouth	☐ Pain around ears	☐ Cold sores/fever blisters
☐ Sensitive teeth	☐ Difficulty chewing	☐ Fluoride in drinking water
	☐ Clenching/grinding teeth	☐ Jaw clicks when chewing

Daily dental health routine: brush ___ x day floss ___ x day other products used ______________________

Do you have concerns about having dental treatment?	☐ Yes	☐ No
Have you ever had a bad experience in a dental office?	☐ Yes	☐ No
Are you dissatisfied with the appearance of your teeth?	☐ Yes	☐ No
Would you like your teeth to be straighter or whiter?	☐ Yes	☐ No
Have you noticed your teeth shifting or crowding over time?	☐ Yes	☐ No

TO THE BEST OF MY KNOWLEDGE, all the preceding answers are true and correct. I understand that this information will be held in the strictest confidence and be used only to improve communication between Doctor and myself. If I have any change, I will inform the dentist at the next appointment without fail. I hereby authorize Doctor to take any diagnostic records deemed necessary to make a thorough diagnosis of dental needs and to perform any and all forms of treatment and therapy agreed upon by me. I authorize my dental care providers and my medical care providers to communicate with information regarding my dental health status.

✖ ______________________________ ______________

Patient Signature Date

OR

✖ ______________________________ ______________ ________

Signature of Parent or Responsible Party Relationship to Patient (Parent, Guardian etc.) Dr.

MEDICAL CHANGES/ UPDATES:

DATE	PATIENT'S SIGNATURE	CHANGES		REVIEWED BY	BP
	X		None ☐		
	X		None ☐		
	X		None ☐		
	X		None ☐		
	X		None ☐		
	X		None ☐		
	X		None ☐		