Mary Seale Churchman, D.D.S.
Katie Courville Roberts, D.D.S.

SSN: _____

PATIENT DENTAL AND MEDICAL HEALTH HISTORY INFORMATION

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Mailing Address _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Gender: _____ Marital Status: _____

Employer: _____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your name and relationship to that person?

Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today: _____

Are you currently experiencing any dental pain or discomfort: ☐ Yes ☐ No If yes, where: _____

Former Dentist: _____ When was your last dental exam?: _____/_____/_____

What was done at the appointment?: _____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**
Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradexa®), clopidogrel (Plavix®), heparin or aspirin)?	☐	☐
If yes, what medication(s) are you taking: _____		
Are you taking any medications to treat **osteoporosis** or Paget's disease? (such as alendronate (Fosamax®, risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), or denosumab (Prolia®)?	☐	☐
If yes, what medication(s) are you taking: _____		
Are you taking or scheduled to take an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer (such as denosumab (Xgeva®, pamidronate (Aredia®, or zolendronate (Zometa®)?	☐	☐
If yes, what medication(s) are you taking: _____ How many years have you been taking it? _____		
Are you taking **hormonal replacements?**	☐	☐
Do you use any form of **tobacco or nicotine products** (such as cigarettes, cigars, snuff, chew, bidis)?	☐	☐
Do you use **vaping products**?	☐	☐
Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons?	☐	☐
If yes, what substances: _____ How often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally		
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason: _____		
Do you take any other **prescriptions and/or over the counter medicine(s), vitamins, herbs and /or supplements?**	☐	☐
If yes, please list them here and include information about how much and how often you use each one: _____		

_____

_____

_____

_____

_____

_____

_____

_____

Please use an "X" to mark your answers to the following questions.

WOMEN ONLY

Are you taking **birth control pills**? ☐ Yes ☐ No

Are you **pregnant**? ☐ Yes ☐ No If yes, number of weeks:_____

Are you **nursing**? ☐ Yes ☐ No

ALLERGIES

Are you allergic to or have you had an allergic reaction to:	**Yes**	**No**
Aspirin	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐
Codeine or other narcotics	☐	☐
Hay fever/seasonal allergies	☐	☐
Iodine	☐	☐
Latex (rubber)	☐	☐
Local anesthetics	☐	☐
Metal	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs such as: sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐
Other	☐	☐

Please describe any "Yes" answers and include information about your experience.

_____

_____

_____

_____

MEDICAL & SURGICAL HISTORY

Doctor's Name: _____

	Yes	**No**
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years	☐	☐
Have you had any type (either total or part) of **joint replacement** surgery (hip, knee, shoulder, elbow, finger, etc.)?	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐

If you answered **"Yes"** to any of the above, please explain.

_____

_____

_____

_____

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the questions completely, accurately and to the best of my ability.

_____

Signature of Patient/Legal Guardian:

_____

Date:

MEDICAL HISTORY SPECIFIC

Please use an "X" to mark your answers to the following questions.

Heart (Cardiac) Health	**Yes**	**No**
Pacemaker/implanted defibrillator	☐	☐
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Congenital heart disease (CHD)	☐	☐
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐
Arteriosclerosis	☐	☐
Coronary artery disease	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur/rhythm disorder	☐	☐
Rheumatic heart disease	☐	☐
Stroke	☐	☐
Breathing (Respiratory) Health		
Asthma (COPD)	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Cancer	☐	☐
Type _____		
Date of diagnosis: _____		
Chemotherapy: _____		
Radiation treatment:_____		
Blood (Circulatory) Health		
Anemia	☐	☐
Blood transfusion	☐	☐
If yes, date: _____		
Hemophilia	☐	☐
High or low blood pressure	☐	☐
Brain (Neurological) Mental Health		
Anxiety	☐	☐
Depression	☐	☐
Epilepsy	☐	☐
Mental Health disorders	☐	☐
Neurological disorders	☐	☐
Post-traumatic stress disorders	☐	☐
Traumatic brain injury or concussion	☐	☐
Autoimmune Disease		
AIDS or HIV Infection	☐	☐
Lupus	☐	☐
Digestive Health		
Gastrointestinal disease	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐
Stomach ulcers	☐	☐
Eye (Vision) Health		
Glaucoma	☐	☐
Other		
Arthritis	☐	☐
Chronic pain	☐	☐
Diabetes (type I or II)	☐	☐
Eating disorder	☐	☐
Frequent infections	☐	☐
Type of infection _____		
Hepatitis, jaundice or liver disease	☐	☐
Immune deficiency	☐	☐
Kidney problems	☐	☐
Malnutrition	☐	☐
Osteoporosis	☐	☐
Rheumatoid arthritis	☐	☐
Sexually transmitted infection (STI)	☐	☐
Thyroid problems	☐	☐

Do you have any disease, condition or problem that's not listed here? If so, explain.

_____

_____