Thomas J. Miller, D.D.S., Inc.

Medical History Form UPDATE 2018

Patient Name: Birth Date: Date

Please answer the following questions Yes or No to be treated on an individual basis for your needs.

DENTAL

Are you having any discomfort at this time ○ Yes ○ No

Have you ever had any serious trouble associated with previous dental treatment? ○ Yes ○ No If yes

Does dental treatment make you nervous?

- ☐ No
- ☐ Slightly
- ☐ Moderately
- ☐ Extremely

Date of last dental visit?

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ○ Yes ○ No If yes

How often do you brush?

Brush is...

☐ Soft ☐ Medium ☐ Hard

Do you use the following?

Brush	○ Yes ○ No
Dental Floss	○ Yes ○ No
Fluoride rinse	○ Yes ○ No
Other	○ Yes ○ No

If you answered "Other" above, please explain ☐ If yes

MOUTH

Bleeding, sore gums	○ Yes ○ No	Unpleasant taste/bad breath	○ Yes ○ No
Burning tongue/lips	○ Yes ○ No	Frequent blisters,lip/mouth	○ Yes ○ No
Swelling/lumps in mouth	○ Yes ○ No	Ortho treatments (braces)	○ Yes ○ No
Biting lips/cheeks	○ Yes ○ No	Clicking/popping jaw	○ Yes ○ No
Difficulty opening or closing jaw	○ Yes ○ No		

TEETH

Loose teeth	○ Yes ○ No	Sensitive to hot	○ Yes ○ No
Sensitive to cold	○ Yes ○ No	Sensitive to sweets	○ Yes ○ No
Sensitive to biting	○ Yes ○ No	Food impaction	○ Yes ○ No
Clenching/grinding	○ Yes ○ No	Shifting in bite	○ Yes ○ No
Change in bite	○ Yes ○ No		

WOMEN

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

☐ Taking hormone therapy ☐ PMS or problems with cycle

MEDICAL

Has there been any change in your general health within the past year? ◯ Yes ◯ No

My last physical exam was on

Are you under a physician's care now? ◯ Yes ◯ No If yes

The name and address of the physician is...

Have you ever had a serious illness within the last 5 years? If so, what was the illness? ◯ Yes ◯ No If yes

Have you ever been hospitalized or had a major operation within the last 5 years? If so, for what? ◯ Yes ◯ No If yes

Do you have or have had any of the following diseases or problems?

Condition	Answer	Condition	Answer	Condition	Answer
Rheumatic Fever	◯ Yes ◯ No	Asthma or Hay Fever	◯ Yes ◯ No	Digestive ulcers disorder	◯ Yes ◯ No
Congenital Heart	◯ Yes ◯ No	Hives or skin rash	◯ Yes ◯ No	Kidney Trouble	◯ Yes ◯ No
Cardiovascular Disease	◯ Yes ◯ No	Fainting spells seizures	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Artificial Valves	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Persistent cough	◯ Yes ◯ No
Pacemaker	◯ Yes ◯ No	Hepatitis, liver disease	◯ Yes ◯ No	Immune disorder	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Venereal disease	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Artificial joints	◯ Yes ◯ No	PRE-MED Required?	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Other	◯ Yes ◯ No
Allergies	◯ Yes ◯ No				

If you answered yes to Cardiovascular disease.

- ☐ Pain in chest upon exertion
- ☐ Short of breath after exercise
- ☐ Do your ankles swell

If you answered yes to Diabetes

- ☐ Had a recent A1C test done?
- ☐ Test your blood sugar daily?
- ☐ Please give us your last A1C result here

Have you had abnormal bleeding associated with previous extractions, surgery or trauma?

Do you bruise easily ◯ Yes ◯ No

Ever had blood transfusion? ◯ Yes ◯ No

If yes to blood transfusion, please explain ◯ Yes ◯ No If yes

Have you ever tested positive for HIV? ◯ Yes ◯ No

Do you have any blood disorder such as anemia? ◯ Yes ◯ No

Have you had surgery or x-ray treatment for cancer, tumor, growth, or other condition? ◯ Yes ◯ No

Are you taking any of the following?

Medication	Answer	Medication	Answer
Antibiotics or sulfa drugs	◯ Yes ◯ No	Anticoagulants (blood thinners)	◯ Yes ◯ No
Meds for high blood pressure	◯ Yes ◯ No	Cortisone (steroids)	◯ Yes ◯ No
Anti-Anxiety-Anti-Depressants	◯ Yes ◯ No	Antihistamines	◯ Yes ◯ No
Aspirin	◯ Yes ◯ No	Insulin, tolbutamide,meds for diabetes	◯ Yes ◯ No
Nitroglycerin	◯ Yes ◯ No	Digitalis or heart meds	◯ Yes ◯ No
Meds for Osteoporosis	◯ Yes ◯ No	Fish Oil	◯ Yes ◯ No
Other Medications	◯ Yes ◯ No		

MEDICATIONS

Please list all your medications below:

ALLERGIES

Are you allergic or have reacted adversly to any of the following:

Local anesthetics	◯ Yes ◯ No	Penicillin or other antibiotics	◯ Yes ◯ No
Sulfa drugs	◯ Yes ◯ No	Barbiturates, sedatives,sleeping pills	◯ Yes ◯ No
Aspirin	◯ Yes ◯ No	Iodine	◯ Yes ◯ No
Codeine or other narcotics	◯ Yes ◯ No	Other	◯ Yes ◯ No

If yes to Other, explain ◯ Yes ◯ No If yes

LIFESTYLE INFORMATION

Do you use any tobacco products? If yes, how much	◯ Yes ◯ No	If yes
Do you use any alcohol products? If yes, how much per day/week/month and what?	◯ Yes ◯ No	If yes
Do you use any caffeinated products? If yes, how much per day and what?	◯ Yes ◯ No	If yes
Do you have any disease, condition, or problem not listed above that you think we should know about?	◯ Yes ◯ No	If yes
Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?	◯ Yes ◯ No	
Do you wear contact lenses?	◯ Yes ◯ No	
Are you experiencing stress or pressure in your work or at home?	◯ Yes ◯ No	

DOCTOR REMARKS: (for office use ONLY) BP: Pulse:

SIGNATURE

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the office at the next appointment.

Signature of Patient, Parent or Guardian:

X Date:___________