**** Family Dentistry of Mukilteo

833 2nd Street Suite A.

Mukilteo, WA 98275

**Medical History**

Are you under the care of a Physician? ☐Yes ☐No

If Yes: Name of Physician: Phone:

Reason for care:

Approximate date of last physical/check-up:

Ever been hospitalized or had a major operation? ☐Yes ☐No

If Yes, please explain:

Have you ever had a serious head or neck injury? ☐Yes ☐No

If Yes, please explain:

Are you taking any medications, pills, drugs, or vitamins? ☐Yes ☐No

Please list all prescription medications (please use separate sheet if needed):

Please list all vitamins and supplements you are taking:

Do you use Tobacco? ☐Yes ☐No

What form of tobacco, how much per day, and for how many years?

Do you/ have you used controlled substances? ☐Yes ☐No

Women: Are you…

Pregnant/Trying to get pregnant? ☐Yes ☐No Nursing? ☐Yes ☐ No

Are you Allergic or have sensitivity to any of the following:

☐Aspirin ☐Sulfa Drugs ☐Codeine/other narcotics ☐Penicillin ☐Other antibiotics

☐Latex ☐Local anesthetics ☐Barbiturates, sedatives, sleeping pills ☐shellfish or iodine

☐Metals ☐Acrylic ☐Other

**Dental History**

Are you currently in dental pain? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐Yes ☐No

If yes, why?

Do you have any dental concerns at the moment? ☐Yes ☐No

If yes, please explain:

Do you have dental anxiety? ☐Yes ☐No

Do your gums bleed when brushing or flossing? ☐Yes ☐No

Do you get mouth sores? ☐Yes ☐No

Do you have dry mouth? ☐Yes ☐No

Do you /have you ever been told that you grind or clench your teeth? ☐Yes ☐No

Have you ever had any pain or clicking or popping in your jaw joints? ☐Yes ☐No

Have you ever been treated for TMJ problems? ☐Yes ☐No

Have you ever been treated for oral cancer? ☐Yes ☐No

Do you have recurring or frequent headaches, migraines? ☐Yes ☐No

Do you have frequent earaches or neck pains? ☐Yes ☐No

Have any of your family members had gum disease? ☐Yes ☐No

Do you brush daily? ☐Yes ☐No

Do you clean between your teeth daily? ☐Yes ☐No

If yes, what devices do you use? ☐Dental floss ☐Tooth picks ☐Waterpik

Do you use mouthwash? ☐Yes ☐No

Do you clean your tongue? ☐Yes ☐No

Are you happy with your smile? ☐Yes ☐No

If no, what would you like to change?

Printed Name: Date: ­­

Signature:

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

AIDS/HIV positive ☐Yes ☐No

Alzheimer’s Disease ☐Yes ☐No

Anaphylaxis ☐Yes ☐No

Anemia ☐Yes ☐No

Angina ☐Yes ☐No

Arthritis/Gout ☐Yes ☐No

Artificial Heart Valve ☐Yes ☐No

Artificial Joint ☐Yes ☐No

Asthma ☐Yes ☐No

Blood Disease ☐Yes ☐No

Blood transfusion ☐Yes ☐No

Breathing Problem ☐Yes ☐No

Bruise easily ☐Yes ☐No

Cancer ☐Yes ☐No

Chemotherapy ☐Yes ☐No

Chest Pains ☐Yes ☐No

Cold Sores ☐Yes ☐No

Congenital Heart Disorder ☐Yes ☐No

Convulsion ☐Yes ☐No

Cortisone Medicine ☐Yes ☐No

Diabetes ☐Yes ☐No

Drug Addiction ☐Yes ☐No

Easily Winded ☐Yes ☐No

Emphysema ☐Yes ☐No

Epilepsy or seizures ☐Yes ☐No

Excessive Bleeding ☐Yes ☐No

Excessive Thirst ☐Yes ☐No

Fainting/dizziness ☐Yes ☐No

Frequent cough ☐Yes ☐No

Frequent Diarrhea ☐Yes ☐No

Frequent headaches ☐Yes ☐No

Gastric reflux ☐Yes ☐No

Genital Herpes ☐Yes ☐No

Glaucoma ☐Yes ☐No

Hay Fever ☐Yes ☐No

Heart Attack/failure ☐Yes ☐No

Heart Murmur ☐Yes ☐No

Heart Pacemaker ☐Yes ☐No

Heart trouble/disease ☐Yes ☐No

Hemophilia ☐Yes ☐No

Hepatitis A ☐Yes ☐No

Hepatitis B or C ☐Yes ☐No

Herpes ☐Yes ☐No

High blood pressure ☐Yes ☐No

High cholesterol ☐Yes ☐No

Hives or Rash ☐Yes ☐No

Hypoglycemia ☐Yes ☐No

Irregular Heartbeat ☐Yes ☐No

Kidney Problems ☐Yes ☐No

Leukemia ☐Yes ☐No

Liver Disease ☐Yes ☐No

Low Blood pressure ☐Yes ☐No

Lung Disease ☐Yes ☐No

Mitral Valve Prolapse ☐Yes ☐No

Osteoporosis ☐Yes ☐No

Pain in Jaw points ☐Yes ☐No

Parathyroid disease ☐Yes ☐No

Psychiatric Care ☐Yes ☐No

Radiation treatments ☐Yes ☐No

Recent weight loss ☐Yes ☐No

Renal Dialysis ☐Yes ☐No

Rheumatic Fever ☐Yes ☐No

Rheumatism ☐Yes ☐No

Scarlet Fever ☐Yes ☐No

Shingles ☐Yes ☐No

Sickle cell disease ☐Yes ☐No

Sinus Trouble ☐Yes ☐No

Sleep apnea ☐Yes ☐No

Stomach/ intestinal disease ☐Yes ☐No

Stroke ☐Yes ☐No

Swelling of limbs ☐Yes ☐No

Thyroid disease ☐Yes ☐No

Tonsillitis ☐Yes ☐No

Tuberculosis ☐Yes ☐No

Tumors or growths ☐Yes ☐No

Ulcers ☐Yes ☐No

Venereal disease ☐Yes ☐No

\*\*Any other conditions not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:

Signature:

Date: