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	Hepatitis A	☐Yes	☐No
Alzheimer's Disease	☐Yes	☐No	Hepatitis B or C	☐Yes	☐No
Anaphylaxis	☐Yes	☐No	Herpes	☐Yes	☐No
Anemia	☐Yes	☐No	High blood pressure	☐Yes	☐No
Angina	☐Yes	☐No	High cholesterol	☐Yes	☐No
Arthritis/Gout	☐Yes	☐No	Hives or Rash	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No	Hypoglycemia	☐Yes	☐No
Artificial Joint	☐Yes	☐No	Irregular Heartbeat	☐Yes	☐No
Asthma	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Blood Disease	☐Yes	☐No	Leukemia	☐Yes	☐No
Blood transfusion	☐Yes	☐No	Liver Disease	☐Yes	☐No
Breathing Problem	☐Yes	☐No	Low Blood pressure	☐Yes	☐No
Bruise easily	☐Yes	☐No	Lung Disease	☐Yes	☐No
Cancer	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Chest Pains	☐Yes	☐No	Pain in Jaw points	☐Yes	☐No
Cold Sores	☐Yes	☐No	Parathyroid disease	☐Yes	☐No
Congenital Heart Disorder	☐Yes	☐No	Psychiatric Care	☐Yes	☐No
Convulsion	☐Yes	☐No	Radiation treatments	☐Yes	☐No
Cortisone Medicine	☐Yes	☐No	Recent weight loss	☐Yes	☐No
Diabetes	☐Yes	☐No	Renal Dialysis	☐Yes	☐No
Drug Addiction	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Easily Winded	☐Yes	☐No	Rheumatism	☐Yes	☐No
Emphysema	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Epilepsy or seizures	☐Yes	☐No	Shingles	☐Yes	☐No
Excessive Bleeding	☐Yes	☐No	Sickle cell disease	☐Yes	☐No
Excessive Thirst	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Fainting/dizziness	☐Yes	☐No	Sleep apnea	☐Yes	☐No
Frequent cough	☐Yes	☐No	Stomach/ intestinal disease	☐Yes	☐No
Frequent Diarrhea	☐Yes	☐No	Stroke	☐Yes	☐No
Frequent headaches	☐Yes	☐No	Swelling of limbs	☐Yes	☐No
Gastric reflux	☐Yes	☐No	Thyroid disease	☐Yes	☐No
Genital Herpes	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Glaucoma	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Hay Fever	☐Yes	☐No	Tumors or growths	☐Yes	☐No
Heart Attack/failure	☐Yes	☐No	Ulcers	☐Yes	☐No
Heart Murmur	☐Yes	☐No	Venereal disease	☐Yes	☐No
Heart Pacemaker	☐Yes	☐No			
Heart trouble/disease	☐Yes	☐No			
Hemophilia	☐Yes	☐No			

**Any other conditions not listed:

_____

_____

_____

Printed Name: _____

Signature: _____

Date: _____