

*Southern Vista Dental Care*  
**Medical/Dental Health Information Record**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical History**

Date of Birth: \_\_\_\_\_

1. Do you currently or have you experienced in the past any of the following: (Please check all that apply)

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS / HIV               | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Stomach Problems          |
| <input type="checkbox"/> Allergies Seasonal       | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Latex Allergy                | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Allergies to Medications | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mental Disorders             | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Allergies to foods/other | <input type="checkbox"/> Growths              | <input type="checkbox"/> Nervous Disorders            | <input type="checkbox"/> Tumors                    |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Ulcers                    |
| <input type="checkbox"/> Artificial Joints        | <input type="checkbox"/> Head injuries        | <input type="checkbox"/> Pregnancy:<br>Due Date _____ | <input type="checkbox"/> Venereal Disease          |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Radiation Treatment          | <input type="checkbox"/> Tobacco use<br>Type _____ |
| <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Respiratory Problems         | For how long _____                                 |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> OTHER: _____              |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> High Blood pressure  | <input type="checkbox"/> Rheumatism                   | _____  |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Jaundice             |   |  |

Please comment on any of the above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2.  Yes  No: Have you ever been *treated* for cancer?  
 Yes  No: If yes, were you ever treated with I.V. bisphosphonates\*?  
Please explain: \_\_\_\_\_

3.  Yes  No: Are you currently taking bisphosphonates\*, (Fosomax, Zometa, Aredia, Pamisol, etc.) for increased bone density?  
Please explain: \_\_\_\_\_

4.  Yes  No: Are you currently taking any blood thinners or anticoagulants (including Aspirin)?  
If yes, please explain: \_\_\_\_\_

**Please list any current medications:**  Please check if you have a list (we will be happy to make a copy for our records).  
Medication: Medication is for:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5.  Yes  No: Have you been admitted to a hospital or received emergency care in the last two years?  
If yes, please explain: \_\_\_\_\_

6. Name of primary care physician: \_\_\_\_\_ Date of last examination: \_\_\_\_\_

7.  Yes  No: Are you currently receiving medical treatment?  
If yes, please explain: \_\_\_\_\_

8. Please list any other medical conditions not listed above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Dental History

1. Reason for today's visit: \_\_\_\_\_ Date of last dental visit: \_\_\_\_/\_\_\_\_/\_\_\_\_
2.  Yes  No: Have you ever had any complications following dental treatment?  
If yes, please explain: \_\_\_\_\_
3.  Yes  No: Do you have any dental pain or sensitivity?  
If yes, please explain: \_\_\_\_\_
4.  Yes  No: Do you have pain in your jaw joint, or a history of T.M.J. discomfort?  
If yes, please explain: \_\_\_\_\_
5.  Yes  No: Do you experience bleeding of your gums when brushing or flossing?
6.  Yes  No: Have you ever been diagnosed with Periodontal Disease? (Including gingivitis)  
 Yes  No: If yes, were you treated with a deep cleaning or Scaling and Root Planning?  
If yes, what was the approximate date? \_\_\_\_/\_\_\_\_/\_\_\_\_
7.  Yes  No: Are you happy with your smile?
8.  Yes  No: Do you, or have you ever had orthodontics (braces)?  
If yes, how long ago? \_\_\_\_\_
9.  Yes  No: Is there anything about your smile you would like to improve?  
Please explain: \_\_\_\_\_
10.  Yes  No: Do you have any concerns or questions you would like the dentist or hygienist to clarify for you?  
Please explain: \_\_\_\_\_
11.  Yes  No: Is there anything we can do to make your visits more comfortable and pleasant?  
Please explain: \_\_\_\_\_

### **Please Note:**

It is our desire to provide the best possible health care for our patients. The above listed questions are designed to help us provide you with optimal, personal care, and will be kept medically confidential as provided by law.

\* Evidence supports that patients who are over 55yrs old, medically compromised, and who have been on IV, and/or prescription medications for the treatment of bone disease and increasing bone density are at an increased risk for healing complications related to dental extractions, bone surgery, and denture irritations.

To the best of my knowledge, all of the preceding answers and medical/dental history provided are true and correct. I also acknowledge that it is essential to my health, and I am responsible to make known any changes in my health, including changes in medication.

**Signature of patient, parent, or guardian: Date:**

**Signature of reviewing dental professional Date:**

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

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