



Welcome to MISSION TRAILS DENTISTRY

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form. If you have any questions or need assistance, please ask us – we will be happy to help.

MEDICAL HISTORY Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No N/A _____
- Have you ever been hospitalized or had a major operation? Yes No N/A _____
- Have you ever had a serious head or neck injury? Yes No N/A _____
- Are you taking any medications, pills or drugs? Yes No N/A _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No N/A _____
- Are you on a special diet? Yes No N/A _____
- Do you use tobacco? Yes No N/A _____
- Do you use controlled substances? Yes No N/A _____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Do you have, or have you had, any of the following?				
Yes	Yes	Yes	Yes	Yes
<input type="checkbox"/> AIDS HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Attack Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur *	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve *	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pace Maker*	<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint*	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble Disease	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growth
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever*	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No N/A _____

If yes, please explain: _____

*Condition may require medication

Some Additional Questions	
Yes	Yes
<input type="checkbox"/> Have you or a bed partner experienced any symptoms of snoring?	<input type="checkbox"/> Do you experience soreness in the jaw in the mornings?
<input type="checkbox"/> Do you ever wake up feeling un-refreshed or still tired?	<input type="checkbox"/> Do you feel you could benefit from a better night's sleep?
<input type="checkbox"/> Have you experienced daytime fatigue throughout the day?	<input type="checkbox"/> Would you like a white smile?
<input type="checkbox"/> Have you or your bed partner awoken gasping for air?	<input type="checkbox"/> Are you interested in sedation dentistry?
<input type="checkbox"/> Do you have issues falling asleep or staying asleep?	<input type="checkbox"/>

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date _____