Draver Dental Medical History

Name: ______ Birthdate: ______ Gender: ______

Phone number cell: ______ Phone number work or home: ______

Address: ______

Email address: ______ How do you wish to be addressed? ______

Emergency Contact : ______ Emergency Contact Phone: ______

	Yes	No
Are you currently being treated by a physician? If so, name and number______	☐	☐
Condition being treated (if other than routine care)?______		
Have you been hospitalized or had a serious illness in the last 5 years?.........	☐	☐
If yes, please explain why: ______		
(Women) Are you pregnant? If so, give due date ______	☐	☐
Do you use tobacco in any form? Do you vape? If yes, how much? ______	☐	☐
Do you use alcoholic beverages (more than 2 drinks a day)?.........	☐	☐
Have you had a joint replacement? Date of surgery and which joint? ______	☐	☐
If yes, surgeon's name and number? ______		
Did the surgeon recommend antibiotic premedication? How long? ______		
Have you had a stroke? If yes, date ______	☐	☐

General	Yes	No	**Heart/Blood Vessels**	Yes	No
Sleep Apnea……...…....….….….	☐	☐	Bacterial Endocarditis……………	☐	☐
Tire Easily, weakness……...……	☐	☐	Rheumatic fever………………….	☐	☐
Wake with or frequent headaches	☐	☐	Heart Murmur………………...…..	☐	☐
Transplants…………...…...……	☐	☐	Chest Pain/Angina……………..…	☐	☐
Eyes/ Nose/ Throat			Heart attack/ disease………...…..	☐	☐
Glaucoma…………………….……...	☐	☐	Shortness of breath……...…...…..	☐	☐
Frequent nosebleeds…………...…	☐	☐	High blood pressure………..........	☐	☐
Sinus problems…………………..	☐	☐	Low blood pressure……………..	☐	☐
Frequent sore throat……….…….	☐	☐	Congenital heart disease..….……..	☐	☐
Nervous System			Artificial heart valve……………..	☐	☐
Seizures/ Epilepsy…….…………	☐	☐	Pacemaker…………………….….	☐	☐
Numbness/ tingling……...……..	☐	☐	Heart Surgery…………...….…..	☐	☐
Dizziness/ fainting…….…………	☐	☐	Bleeding disorder……...……….	☐	☐
Anxiety.....................……..…...	☐	☐	Bruise easily…………………...…	☐	☐
Depression..................................	☐	☐	Anemia……………………….…..	☐	☐
Respiratory			**Digestive System**		
Tuberculosis………..…...…..….	☐	☐	Liver disease/ Hepatitis…...…..…	☐	☐
Emphysema…….….….…………	☐	☐	Ulcers……………………..…......	☐	☐
Asthma/ hay fever……....………..	☐	☐	**Urinary**		
Persistent cough…...…..…………	☐	☐	Kidney disorders……….…....….	☐	☐
Trouble breathing if lying down	☐	☐	Venereal disease……….…...…...	☐	☐
Endocrine/Bone/Muscular			**Other**		
Diabetes…………….….……...…	☐	☐	Drug Addiction…………….…..…	☐	☐
Thyroid condition/ goiter……..…	☐	☐	Radiation or chemotherapy.............	☐	☐
Arthritis/rheumatism.....................	☐	☐	Cancer/tumor/growth.......................	☐	☐
Osteoporosis/bone disease................	☐	☐	AIDS/HIV…………………….......	☐	☐

Are you ALLERGIC or have you ever experienced any reaction to the following?

	Yes	No
Penicillin………..……..……...…….		
Local Anesthetics(e.g. novocaine)…..		
Barbiturates/sedatives/sleeping pill…		
Latex……………...………………		
Aspirin……………...…………….		
Codeine……………….....………….		
Sulfa drugs……………………….		

Other allergies: ___________________________

Are you taking or have you recently taken any of the following?

	Yes	No
Antibiotics/ Sulfa drugs……..….....		
Blood thinners………………..…...…		
Blood pressure medications…..…..		
Thyroid Medicine………………..		
Cortisone/ Steroids…………….....		
Bisphosphonates………...……….		
Recreational drugs………………..		
Nitroglycerin…………………..…..		
Aspirin…………….……………...		
Digitalis/ other heart drugs..…...…		

Please list the medications currently being taken and dosage below:

____

____

____

____

Is there any disease, condition or problem not listed above, or is there any activity your doctor says you cannot do?

____

Do you have any of the following dental concerns?

	Yes	No
Bleeding gums..............................		
Dry mouth…………….…...…		
Prior gum surgery/deep cleaning......		
Grinding, jaw pain, headaches……...		
Missing teeth you want replaced........		
Sores or ulcers in your mouth..........		
Are you interested in whitening..........		
Are you happy with your smile..........		

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 medication, I will inform the dentist at the next appointment.

Signature of the Patient, Parent, or Guardian: ________________________________ Date: __________

FOR FUTURE APPOINTMENT DATES ONLY:

I have reviewed this information and to the best of my knowledge it is accurate.

Signature Date

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