CHERI C. BLOOM, DDS

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Patient Name:_____ **M:** ☐ **F:**☐ **DOB:**_____ **Age:**_____ **Date:** _____

MEDICAL HISTORY FORM

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medications you take, could have an important interrelationship with the dental care you will receive. Your privacy is important to us and your answers will be kept confidential. Thank you.

Please list your family physician and any medical specialist you see at least once a year:

Name	Phone Number	Specialty

Hospitalizations/Surgeries: _____

Check (✓) if you have or have had any of the following:

☐ **Allergic Reactions (circle): Latex Penicillin Aspirin Codeine Local Anesthesia Metal Other** _____

☐ **Artificial Joints* (circle): Hip Knee Shoulder Other**_____ **Date** _____
(*Sometimes requires antibiotic pre-med for 2 years or more following placement)

☐ **Artificial heart valves**
☐ **Anemia/Hemophilia/Blood disease**
☐ **Chemical dependency**
☐ **Congestive heart failure**
☐ **Diabetes ☐ Type I ☐ Type II**
☐ **Epilepsy/Seizures**
☐ **Glaucoma**
☐ **GERD/Reflux/Heartburn**
☐ **Heart stents Date:** _____
☐ **Heart murmur/Mitral valve prolapse/Endocarditis**
☐ **Heart attack Date:**_____
☐ **Heart bypass Date:** _____
☐ **Hepatitis* or Liver Disease *Type:**_____
☐ **High Blood Pressure**
☐ **Osteoporosis therapy Type/Date:** _____

☐ **Immune suppressive condition:**
  ☐ **Steroid therapy (prednisone)** ☐ **Scleroderma/Lupus**
  ☐ **Organ Transplant** ☐ **Rheumatoid arthritis**
  ☐ **Spleen Removal** ☐ **HIV/AIDS**
☐ **Kidney disease**
☐ **Dialysis**
☐ **Parkinson's, ALS, MS or other nervous system disorder**
☐ **Pacemaker or irregular heartbeat**
☐ **Psychiatric care**
☐ **Respiratory disease:**
  ☐ **Emphysema** ☐ **Shortness of breath**
  ☐ **Tuberculosis** ☐ **Asthma**
☐ **Stroke Date:**_____ ☐ **Tonsils/Adenoids Removed Date** _____
☐ **Thyroid or Parathyroid**
☐ **Tobacco Use** ☐ **Smoke** ☐ **Chew # of yrs.** _____

Women: Pregnant? ☐ **Yes** ☐ **No** **Nursing?** ☐ **Yes** ☐ **No** **Birth Control Pills?** ☐ **Yes** ☐ **No**

☐ **Cancer Type/Date:**_____

Treatment: ☐ **Chemotherapy** ☐ **Radiation** ☐ **Bisphosphonates** ☐ **Oral Suppressants**

☐ **Herbal Medications or Dietary Supplements you are taking (circle):**

Garlic Kava Valerian Fever few Gingko Ginseng Echinacea Other_____

List all medications you are taking:

_____
_____
_____
_____

Other conditions not listed above:

_____
_____
_____
_____

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Medical History Form Continued

Patient Name:_____ **DOB:**_____ **Date:** _____

DENTAL HISTORY

Date of Last Dental Care: _____

Former Dentist: _____

Address:_____

Phone:_____

Current problems with teeth or mouth:

_____

_____

_____

Check (✓) if you have or have had any of the following:

- ☐ Clicking ☐ Popping ☐ Jaw Pain
- ☐ Snoring ☐ CPAP Appliance ☐ Snoring Guard
- ☐ Headaches or migraines
- ☐ Clenching or grinding teeth
- ☐ Wear or have worn a night guard
- ☐ Sensitivity to chewing or pressure
- ☐ Sensitive to hot
- ☐ Sensitive to cold
- ☐ Sensitive to sweets
- ☐ Sores or growths in your mouth
- ☐ Wear dentures/partial Age of prosthetic: _____
- ☐ Wisdom teeth removed
- ☐ Orthodontics/braces
- ☐ Odors or bad taste in mouth
- ☐ Periodontal disease, treatment or diagnosis
- ☐ Food collection between teeth
- ☐ Canker Sores ☐ Cold sores
- ☐ Injury to face, jaws or teeth Date: _____
- ☐ Anorexia/Bulimia
- ☐ Other: _____

Are you happy with the appearance of your teeth? ☐ Yes ☐ No

Would you like your teeth: ☐ Straightened ☐ Whitened ☐ Changed in length/shape?

How often do you brush?_____ **How often do you floss?** _____

SIGNATURE

The information contained on this form is accurate and complete to the best of my knowledge. I will not hold Dr. Bloom or any member of her staff responsible for any errors or omissions that I have made in the completion of this form.

Date:_____ **Signature:** _____