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 _______________________
(*Requires antibiotic pre-med for 2 yrs after placement)

☐ Artificial heart valves
☐ Anemia/Hemophilia/Blood disease
☐ Chemical dependency
☐ Congestive heart failure
☐ Diabetes ☐ Type I ☐ Type II
☐ Epilepsy/Seizures
☐ Glaucoma
☐ GERD or Reflux
☐ Heart stents Date: ___________
☐ Heart murmur or Mitral valve prolapse
☐ 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
☐ Parkinson's, ALS, MS or other nervous system disorder
☐ Rheumatic fever/rheumatic heart disease/endocarditis
☐ Pacemaker or irregular heartbeat
☐ Psychiatric care
☐ Respiratory disease:
  ☐ Emphysema ☐ Shortness of breath
  ☐ Tuberculosis ☐ Asthma
☐ Stroke 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

☐ **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:

____
____
____
____

CHERI C. BLOOM, DDS

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 or popping jaw
- ☐ Pain in jaw
- ☐ Headaches or migraines
- ☐ Clenching or grinding teeth
- ☐ Wear or have worn a night guard
- ☐ Sensitivity to cold
- ☐ Sensitivity to biting or eating
- ☐ Sensitive to hot
- ☐ 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
- ☐ Cold sores
- ☐ Injury to face, jaws or teeth
- ☐ 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:** ______________________________