LifeSmiles Dental LLC

Medical History / Dental History(2025)

Patient Name: Birth Date: Date Created:

For Office Use...

Today's Radial Blood Pressure: Today's Pulse: Today's CC:

Disclaimer

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 relationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Have you had any changes to your health in the past year(s)?	Yes	No	If yes
Do you have a primary care physician? (name, date of last visit)	Yes	No	If yes
Do you see a specialist physician? (name, date of last visit)	Yes	No	If yes
Do you have an artificial joint? (type, year of surgery, surgeon)	Yes	No	If yes
Has a physician recommended you take antibiotics prior to your dental treatment?	Yes	No	If yes
Have you ever been diagnosed with cancer? (type, year diagnosed)	Yes	No	If yes

Cancer Treatment received.....

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Surgery

Question			
Have you ever had a serious head or neck injury?	Yes	No	If yes
Have you had a heart attack or stroke? If yes, please list dates and type.	Yes	No	If yes
Have you ever been hospitalized or had a major operation other than listed above?	Yes	No	If yes
Do you currently use tobacco? (Please list the type smoking/chewing/pouches/vaping)	Yes	No	If yes
Do you use controlled substances (drugs) or marijuana?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Are you taking any medications, drugs, pills, or supplements? (Please list or have photocopied.)	Yes	No	If yes
Are you on a blood thinner?	Yes	No	If yes
Are you pregnant? If yes, how many weeks?	Yes	No	If yes

Women: Are you...

- ☐ Are you nursing?
- ☐ Trying to get pregnant?
- ☐ Taking oral contraceptives?

Do you have, or have you had, any of the following?

Condition			Condition			Condition			Condition		
Infective Endocarditis	Yes	No	Cochlear Implant	Yes	No	Fainting or Dizziness	Yes	No	Pacemaker	Yes	No
Artificial Heart Valve	Yes	No	Cold Sores/Fever Blisters	Yes	No	Frequent Headaches/Migraines	Yes	No	Psychiatric Care	Yes	No
AIDS/HIV Positive	Yes	No	Congenital Heart Disorder	Yes	No	Heart Attack/Failure	Yes	No	Recurrent Infections	Yes	No
Acid Reflux	Yes	No	Dementia	Yes	No	Hemophilia	Yes	No	Shingles	Yes	No
Asthma	Yes	No	Development Disorder	Yes	No	Hepatitis B or C	Yes	No	Sinus Trouble	Yes	No
Autoimmune Disease	Yes	No	Diabetes	Yes	No	High Blood Pressure	Yes	No	Sleep Disorder	Yes	No
Breathing Problems	Yes	No	Drug Addiction	Yes	No	Kidney Problems	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Eating Disorder	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Chest Pains	Yes	No	Epilepsy or Seizures	Yes	No	Lung Disease	Yes	No	Tumors or Growths	Yes	No
Chronic Pain	Yes	No	Hearing Impairment	Yes	No	Mental Health Disorder	Yes	No	Visual Impairment	Yes	No

Have you ever had any serious illness not listed above? Yes No If yes

Are you allergic to any of the following?

- ☐ Acrylic
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Aspirin
- ☐ Latex
- ☐ Metal
- ☐ Sulfa Drugs

Other Drug Allergies? Yes No If yes

Question			
Is there a specific reason for today's visit?	Yes	No	If yes
Are you having discomfort at this time?	Yes	No	If yes
Is there anything you would change with your smile?	Yes	No	If yes

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:

X Date:___________