Metropolitan State University Dental Therapy Clinic
Medical History

Please complete the following medical history form honestly and completely. Health conditions and medications can affect your oral health and the dental care we provide. Our office adheres to written policies and procedures to protect the privacy of your health information. If you need assistance filling out this form or have a question about the form please let your provider know.

Patient Name:_____ Date of Birth: _____ Date: _____

General Health Questions:			
Are you Currently under a physician's care?	☐ Yes	☐ No	If yes please describe:
Have you been hospitalized in the last year?	☐ Yes	☐ No	If yes please describe:
Have you ever had a major operation?	☐ Yes	☐ No	If yes please describe:
Have you ever taken a medication for osteoporosis?	☐ Yes	☐ No	If yes please describe:
Have you ever been told you need to take an antibiotic BEFORE dental treatment?	☐ Yes	☐ No	If yes please describe:

Medications
Are you currently taking any medications, pills, vitamins or supplements? ☐ Yes ☐ No
If YES please list the name, dose and time of day you take the medication, pill, vitamin and supplement:

Allergies			
Do you have seasonal or environmental allergies? ☐ Yes ☐ No			
Have you or anyone in your family ever had an adverse reaction to general or local anesthesia? ☐ Yes ☐ No			
Are you allergic to any of the following? (check all the apply)			
☐ Aspirin	☐ Ibuprofen	☐ Latex	☐ Local Anesthesia
☐ Antibiotics	☐ Opioids	☐ Codeine	☐ Food (Gluten, shellfish, nuts, ect)
Are you allergic or sensitive to any other substance? If so please list:			

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For women, are you:		
Pregnant/Trying to get pregnant? ☐ Yes ☐ No	Nursing? ☐ Yes ☐ No	Taking Contraceptives? ☐ Yes ☐ No

Medical Conditions Do you currently or have ever had any of the following:			
1. Arthritis	☐ Yes ☐ No	2. Liver Disease	☐ Yes ☐ No
3. Heart Surgery	☐ Yes ☐ No	4. Cancer	☐ Yes ☐ No
5. History of Endocarditis	☐ Yes ☐ No	6. Chemotherapy	☐ Yes ☐ No
7. Cardiac Pacemaker	☐ Yes ☐ No	8. Radiation Therapy	☐ Yes ☐ No
9. Congestive Heart Failure	☐ Yes ☐ No	10. Diabetes	☐ Yes ☐ No
11. Heart Attack	☐ Yes ☐ No	12. Kidney/Renal Disease	☐ Yes ☐ No
13. Artificial or Damaged Heart Valve	☐ Yes ☐ No	14. Osteoporosis	☐ Yes ☐ No
15. Mitral Valve Prolapse	☐ Yes ☐ No	16. Bisphosphonate Therapy	☐ Yes ☐ No
17. Angina	☐ Yes ☐ No	18. Tuberculosis	☐ Yes ☐ No
19. High Cholesterol	☐ Yes ☐ No	20. Night Sweats	☐ Yes ☐ No
21. High or Low Blood Pressure	☐ Yes ☐ No	22. Persistent Cough	☐ Yes ☐ No
23. Stroke	☐ Yes ☐ No	24. Cough with Blood	☐ Yes ☐ No
25. Cardiac or Organ Transplant	☐ Yes ☐ No	26. Lung Disease	☐ Yes ☐ No
27. Mental Health Disorder	☐ Yes ☐ No	28. Asthma	☐ Yes ☐ No
29. Sickle Cell Disease	☐ Yes ☐ No	30. Anemia	☐ Yes ☐ No
31. Bleeding Disorders (Hemophilia, excessive bleeding, ect)	☐ Yes ☐ No	32. Human Immunodeficiency Virus (HIV) or Acquired immunodeficiency syndrome (AIDS)	☐ Yes ☐ No
33. Epilepsy and/or Seizures	☐ Yes ☐ No	34. Autoimmune Disease	☐ Yes ☐ No
35. Multiple Sclerosis	☐ Yes ☐ No	36. Development Disability	☐ Yes ☐ No
37. Alzheimer's Disease	☐ Yes ☐ No	38. Thyroid Disorder or Disease	☐ Yes ☐ No
39. Spina Bifida	☐ Yes ☐ No	40. Sinus Troubles or Surgeries	☐ Yes ☐ No
41. Gout	☐ Yes ☐ No	42. Joint Replacement	☐ Yes ☐ No
43. Hepatitis A, B or C		44. Glaucoma	

Please list any conditions or serious illness not listed above:

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Dental History					
When was your last dental visit?					
Have you had dental x-rays with in the past year?	☐ Yes	☐ No			
Have you ever had braces?	☐ Yes	☐ No	Have you ever had jaw surgery?	☐ Yes	☐ No
Have you had your wisdom teeth removed?	☐ Yes	☐ No	Have you ever had a deep cleaning or Scaling and Root Planing (SRP)	☐ Yes	☐ No
Have you been vaccinated for Human Papillomavirus (HPV)	☐ Yes	☐ No			
Do you like your smile?	☐ Yes	☐ No			

Current Dental Problems Do you currently have any of the following:					
Broken Teeth	☐ Yes	☐ No	Sensitivity to biting and/or chewing	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No	Sensitivity to hot and/or cold	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No	Dental Anxiety	☐ Yes	☐ No

Alcohol, Tobacco and Drug Use					
Do you use tobacco products?	☐ Yes	☐ No	If yes, how long have you used tobacco:		
What tobacco products do you use? (Check all the apply) ☐ Cigarettes ☐ Chewing Tobacco/Snuff ☐ Vaping/E-Cigarette ☐ Cigars					
Have you ever tried quitting tobacco?	☐ Yes	☐ No	Are you Interested in information about quitting tobacco use?	☐ Yes	☐ No
Do you drink alcoholic beverages?	☐ Yes	☐ No			
If yes, how many alcoholic drinks do you typically drink in a sitting?			How many days per week do you typically drink alcohol?		
Do you use recreational or medical cannabis (marijuana)?	☐ Yes	☐ No			

Your medical history will be reviewed by your provided and entered into your electronic heath record. Once your electronic health record has been entered you will be asked to sign your medical history.