ORAZIO DENTAL

Name: _____

Date: _____

Patient Dental & Medical History

Thank you for filling out this form thoroughly and truthfully. The info you provide will inform and guide our care for your health & safety.

DENTAL HISTORY & SYMPTOMS

Reason for today's visit:	Are you currently in pain?
When was your last dental exam? dental x-rays? dental cleaning?	
Name of most recent dental provider:	

Please mark an "X" in the box ONLY if the following applies to you:

It hurts to chew, bite or swallow	☐	I have had periodontal cleanings like scaling and root planning	☐
I am aware that I clench or grind my teeth	☐	I have my teeth cleaned more frequently than every 6 mos.	☐
At times, my jaw clicks, pops or is painful	☐	My gums bleed or have pain when brushing or flossing	☐
I experience frequent headaches, neck or ear pain	☐	Dental appointments cause me anxiety	☐
My teeth are bothered by cold or hot temperatures	☐	I have had traumatic dental experiences	☐
I currently wear a night guard/splint	☐	I have had a negative reaction to dental anesthetics	☐
I have had or am currently in orthodontic treatment	☐	I suspect or have been diagnosed w/sleep-disordered breathing	☐
I currently wear an orthodontic retainer	☐	I wear an oral appliance for snoring or sleep apnea	☐
I wear a denture or partial denture	☐	I have had serious injury OR surgery to my head or mouth	☐
I have one or more dental implants	☐	I receive botox/collagen injections in my face/head/neck	☐
I am dissatisfied with the appearance of my smile ☐ Please explain:		Please add anything else you feel is important:	

How often do you brush? Do you use an electric toothbrush? How often do you floss?

ALLERGIES & INTOLERANCES Please mark an "X" in the box ONLY for those that apply to you.

Aspirin	☐	Latex	☐
Codeine or other narcotics	☐	Metals / Jewelry	☐
Dental anesthetics	☐	Penicillin or other antibiotics	☐
Gluten	☐	Sulfa drugs / erythromycin	☐
Hay fever / Seasonal allergies	☐	Sulfites	☐
Iodine	☐	Other – Please list:	☐

MEDICATIONS & OTHER SUBSTANCES Please use an "X" to mark your answers to the following questions.

	Yes	No
Are you taking any **blood thinners**? Type:	☐	☐
Are you taking any medication to control **osteoporosis**? Type:	☐	☐
Do you use any form of **tobacco or nicotine** products? In what form and how often:	☐	☐
Do you use **vaping** products?	☐	☐
Do you use marijuana? In what form and how often:	☐	☐
Do you use **controlled substances** or have a history of abuse? Please explain:	☐	☐
Do you take any other **prescription or over-the-counter medication, vitamins, herbs or supplements?** **Please list:**	☐	☐

MEDICAL & SURGICAL HISTORY

Date of last physical exam:	What is your typical blood pressure?
Primary Care Doctor's Name:	Phone number:

Please use an "X" to mark your answers to the following questions.	Yes	No
Are you in good physical health?	☐	☐
Are you currently being treated for an active health concern? If so, what?	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** prior to dental appointments?	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐
Have you had any type (total or partial) of **joint replacement**?	☐	☐
Have you had **heart valve replacement or heart surgery**?	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐

If you answered yes to any of the above, please explain:

Women only: Pregnant? If yes, number of weeks: Nursing? Taking birth control pills?

MEDICAL HISTORY – SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No
Heart (Cardiac) Health		
Pacemaker/defibrillator	☐	☐
Artificial (prosthetic) valve	☐	☐
Previous infective endocarditis	☐	☐
Congenital heart disease (CHD)	☐	☐
Arteriosclerosis	☐	☐
Coronary artery disease	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Rheumatic heart disease	☐	☐
Stroke	☐	☐
Breathing (Respiratory) Health		
Asthma (COPD)	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Autoimmune Disease		
AIDS or HIV infection	☐	☐
Lupus	☐	☐

	Yes	No
Cancer	☐	☐
Type:		
Date of diagnosis:		
Chemotherapy: Y / N		
Radiation: Y / N		
Blood (Circulatory) Health		
Anemia	☐	☐
Blood transfusion	☐	☐
Hemophilia	☐	☐
High or low blood pressure	☐	☐
Brain (Neurological) / Mental Health		
Anxiety	☐	☐
Depression	☐	☐
Epilepsy	☐	☐
Mental health disorders	☐	☐
Neurologic disorders	☐	☐
Post-traumatic stress disorder	☐	☐
Traumatic brain injury	☐	☐

	Yes	No
Digestive Health		
Gastrointestinal disease	☐	☐
GE reflux/persistent heartburn (GERD)	☐	☐
Stomach ulcers	☐	☐
Eye Health		
Glaucoma	☐	☐
Other		
Arthritis	☐	☐
Chronic pain/Fibromyalgia	☐	☐
Diabetes (type I or II) - Recent A1c:____	☐	☐
Eating disorder	☐	☐
Frequent infections	☐	☐
Type of infection:		
Hepatitis, jaundice or liver disease	☐	☐
Immune deficiency	☐	☐
Kidney problems	☐	☐
Malnutrition	☐	☐
Osteoporosis	☐	☐
Rheumatoid arthritis	☐	☐
Sexually transmitted infection (STI/STD).	☐	☐
Type of infection:		
Thyroid problems	☐	☐

Do you have any other disease, condition or problem that is not listed here? If so, please explain:

***Note: It is important for doctor and patient to communicate honestly about the patient's overall health before dental treatment begins. Many conditions have oral implications that are uncommonly known and important to review.**

I have answered the above questions completely, accurately and to the best of my ability.

SIGNATURE of Patient/Legal Guardian: Date:

Space below is reserved for documentation of updates/changes at future visits.
