Designing Smiles Medical History

Last Name: First Name: Birthdate:

Emergency Contact: _____ Phone: _____ Relationship:

Name of Medical Doctor: _____ Location/Phone: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part your entire body, Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.Thank you for answering the following questions.

List all medications including regular intake of grapefruit, vitamins, herbal supplements, fish oil, etc.

More than 5 medications, please email a picture of your medication list/labels to info@smilesmn.com

_____

_____

Are you allergic to any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Erythromycin	☐	☐	Penicillin	☐	☐	Sulfa
☐	☐	Codeine	☐	☐	Latex	☐	☐	Seasonal	☐	☐	Other: _____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Alcohol/Chemical Dependency	☐	☐	Diabetes	☐	☐	Neurological Disorders
☐	☐	Anxiety / Nervousness	☐	☐	Epilepsy / Seizures	☐	☐	Osteoporosis/Osteopenia
☐	☐	Asthma/Lung Disease	☐	☐	Glaucoma	☐	☐	Pregnancy/Nursing
☐	☐	Arthritis/Rheumatoid Arthritis	☐	☐	Heartburn / GERD / Reflux	☐	☐	Psychiatric Treatment
☐	☐	Artificial Joints/Valves	☐	☐	Heart Problems	☐	☐	Recreational Drug Use
☐	☐	Blood Transfusion	☐	☐	Mitral Valve Prolapse	☐	☐	Rheumatic Fever
☐	☐	Bulimia/Eating Disorder	☐	☐	Hepatitis	☐	☐	Sinus Trouble
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Sleep Apnea
☐	☐	Cold Sores	☐	☐	HIV / AIDS	☐	☐	Stroke
☐	☐	Chemo/Radiation Therapy	☐	☐	Kidney Disease	☐	☐	Thyroid Disease
☐	☐	Depression	☐	☐	Liver Disease	☐	☐	Tuberculosis

Please list any other Medical Conditions/Recent Surgeries/Hospitalizations that may not be listed above:

_____

Do you consume soda/hard candies/frequent snacks? _____

Tobacco use? ☐ Y ☐ N If Yes, what kind and how much?

How would you rate your stress level? ☐ High ☐ Moderate ☐ Low

How would you rate the quality of your sleep? ☐ Very Restful ☐ Adequate ☐ Poor/Interrupted

Comments:

Signature:

Date: