Granada Dental

Reviewed by ________________

Patient Name: ____

MEDICAL HISTORY *(Please circle your response)*

1. Are you being treated for any medical conditions at the present or have you been treated within the past year? If yes, please explain? — Yes No Maybe/Unsure
2. Has there been any changes to your general health in the past year? If yes, please explain? — Yes No Maybe/Unsure
3. Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? If yes, please list? — Yes No Maybe/Unsure
4. Do you have any allergies or have you had an unusual reaction to any drugs or medications? If yes, please list and explain the reaction. — Yes No Maybe/Unsure
5. Have you ever been hospitalized for any illnesses or operations? If yes, please explain? — Yes No Maybe/Unsure
6. Do you or have you ever had any heart, blood pressure problems, or bleeding problems? — Yes No Maybe/Unsure
7. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease), or a heart transplant? — Yes No Maybe/Unsure
8. Do you or have you ever had asthma? — Yes No Maybe/Unsure
9. Do you have any conditions or therapies that could affect your immune system? (eg. Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy) — Yes No Maybe/Unsure
10. Do you or have you ever had hepatitis, jaundice, or liver disease? — Yes No Maybe/Unsure
11. Do you have a bleeding problem, bleeding disorder, or are you on blood thinners? — Yes No Maybe/Unsure
12. Do you have or have you ever had any of the following? Please check.

☐ Chest pain, angina	☐ Heart attack	☐ Stroke	☐ Shortness of breath
☐ Rheumatic fever	☐ Pacemaker	☐ Heart murmur	☐ Mitral valve prolapse
☐ Lung disease	☐ Tuberculosis	☐ Cancer	☐ Steroid therapy
☐ Diabetes	☐ Stomach ulcers	☐ Arthritis	☐ Seizures (Epilepsy)
☐ Kidney disease	☐ Osteoporosis medications (eg. Fosamax)		☐ Drug/Alcohol dependency

13. Are there any conditions or diseases not listed above that you have or have had? If so, please explain. — Yes No Maybe/Unsure
14. Is there any family history of disease? If so, please explain? — Yes No Maybe/Unsure
15. Are you a smoker? If so, how much? — Yes No Maybe/Unsure
16. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? — Yes No Maybe/Unsure
17. Are you in good health? — Yes No Maybe/Unsure
18. Is there any other information regarding your health which was not covered above? — Yes No Maybe/Unsure

DENTAL HISTORY

1. What dental condition concerns you at present?
2. When was your last visit to the dentist?
3. Do you have any sore, aching, sensitive, or loose teeth? — Yes No Maybe/Unsure
4. Do you or have you ever had any jaw joint (TMJ) problems, or any oral habits such as clenching, grinding or nail biting? — Yes No Maybe/Unsure
5. Do you have or have you ever had an occlusal splint (night guard) — Yes No Maybe/Unsure
6. Are you happy with the appearance of your teeth? — Yes No Maybe/Unsure

To the best of my knowledge, the above information is correct.

Patient/Parent/Guardian Signature: ______________________________ **Date**: ______________