Platinum Dental, Inc.

Medical & Dental Health History

Do You have or have you had any of the following? Please check only if yes.

- ☐ Artificial heart valves
- ☐ Infective endocarditis
- ☐ Congenital heart disease/defect
- ☐ Prosthetic joints/hips/knees
- ☐ Pacemaker Date
- ☐ Heart attack Date
- ☐ Stroke Date
- ☐ Diabetes
- ☐ Blood pressure: high/low
- ☐ Bleeding/clotting disorder
- ☐ Hepatitis/Liver disease
- ☐ Blood disorder, anemia, leukemia
- ☐ Kidney disorder/failure
- ☐ Tired/aching jaw muscles
- ☐ Jaw/facial pain/soreness/tingling/numb
- ☐ Headaches
- ☐ Neck/back pain/stiffness/soreness
- ☐ Shoulder/arm pain/tingling/numb
- ☐ Tinnitus/ringing in ears
- ☐ Ear stuffiness/fullness
- ☐ Earaches/Itchy ears
- ☐ Dizziness/Loss of balance
- ☐ Crooked/missing teeth/change in bite
- ☐ Locked/stuck/difficulty opening/closing
- ☐ Clicking/popping jaw eating/talking
- ☐ Difficulty chewing/swallowing/choking
- ☐ Lung trouble (TB, COPD, asthma, emphysema)
- ☐ Shortness of breath or hyperventilation
- ☐ Arthritis, Rheumatoid, Degenerative Joint Disease
- ☐ Convulsions/seizures/epilepsy/fainting spells
- ☐ Anxiety/nervous/mood disorders/imbalance
- ☐ Indium, cobalt, lithium therapy
- ☐ Cancer/tumor/masses benign/malignant
- ☐ Radiation therapy/chemotherapy
- ☐ Gastrointestinal disorders
- ☐ HIV/AIDS/Auto-immune disorders
- ☐ Sexually transmitted diseases/venereal disease
- ☐ Surgeries:
- ☐ Other:

Are you now taking any medications? (check only those that apply)

- ☐ Pain
- ☐ Headaches
- ☐ Arthritis
- ☐ Allergy
- ☐ GERD
- ☐ Stomach
- ☐ Cholesterol
- ☐ Thyroid
- ☐ Blood pressure
- ☐ Blood thinners
- ☐ E.D.
- ☐ Weight loss
- ☐ Osteoporosis
- ☐ Sleeping
- ☐ Anxiety
- ☐ Birth Control
- ☐ Hormone
- ☐ Vitamins
- ☐ Herbal
- ☐ Other

List current medications below

Primary Care Doctor | Date of Last Medical Exam: | Phone:

(women only) Any possibility you are pregnant? ◯ Yes ◯ No

Are you allergic to, have gotten sick from or been told to avoid any of the following?

- ☐ Latex
- ☐ Antibiotics
- ☐ Aspirin/NSAID's
- ☐ Metals
- ☐ Narcotics
- ☐ Anesthetics

Please list what you are allergic to (meds/other)

Have you taken Oral Bisphosphonates like Fosomax (Alendronate)? ◯ Yes ◯ No

Have you taken diet drug Fen-Phen in the past? ◯ Yes ◯ No

Have you seen a dentist in the last 12 months?	◯ Yes	◯ No
Do you currently have dental or facial pain?	◯ Yes	◯ No
Do your gums bleed when you brush or floss?	◯ Yes	◯ No
Do you wake up with sore teeth or tired jaws?	◯ Yes	◯ No
Have you been told you snore loudly?	◯ Yes	◯ No
Do you have any teeth that hurt when you eat?	◯ Yes	◯ No
Do you have crooked or missing teeth?	◯ Yes	◯ No
Do you get anxious or nervous going to dentist?	◯ Yes	◯ No

What is your main reason for seeking dental care now?

- ☐ Check-up
- ☐ TMJ Pain
- ☐ Braces/Invisalign
- ☐ Implants
- ☐ Emergency
- ☐ Sedation dentistry
- ☐ Sleep apnea/Snoring
- ☐ Improve smile/appearance
- ☐ Full mouth reconstruction
- ☐ Whitening
- ☐ Other

I, the undersigned, have given the above information, have reviewed it an find it accurate. If there are any later changes, I will so inform the practice.

Patient signature:

Patient name: Date:

Submit by Email

Print Form