Gentle Dentistry
of Columbus

MEDICAL HISTORY

Full Name:_______________________________________
Date of Birth:_______________
Primary Care Physician:__________________________

Medical Conditions: Please Check Y or N for ALL Medical Conditions Listed Below

Y / N	Condition	Y / N	Condition	Y / N	Condition
☐☐	AIDS/HIV	☐☐	Epilepsy	☐☐	Mitral Valse Prolapse
☐☐	Anemia	☐☐	Excessive Bleeding	☐☐	Pace Maker
☐☐	Arthritis	☐☐	Heart Valve Replacement	☐☐	Psychiatric Care
☐☐	Asthma	☐☐	High Blood Pressure	☐☐	Seizures
☐☐	Cancer	☐☐	Jaw Pain	☐☐	Sickle Cell Disease
☐☐	Chest Pain	☐☐	Heart Attack/Failure	☐☐	Stroke
☐☐	Cold Sores/Fever Blisters	☐☐	Hepatitis: A B C (circle)	☐☐	Thyroid Disease
☐☐	Congenital Heart Defect	☐☐	Joint Replacement	☐☐	Tobacco Use
☐☐	Diabetes Type I or II (circle)	☐☐	Kidney Disease	☐☐	Tuberculosis
☐☐	Drug Addiction	☐☐	Liver Disease	☐☐	Pregnancy

Do you have any illness that is not listed above? If so, what is it?:________________________
Do you take a premedication? What is it?:________________________
Do you have any allergies? Please list: ____

List Medications That You Are Taking Below:

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Dental History: Please Check Y or N

Y / N
☐☐ I have dental exams, cleanings, and x-rays taken routinely.
☐☐ I frequently have discomfort, popping, and/or soreness in my jaw.
☐☐ My gums are sensitive and prone to bleeding when I floss or brush.
☐☐ I like my smile. If not, why?: ____
☐☐ I have had dental procedures done in the past (crowns, fillings, extractions) that need attention.
☐☐ I have anxiety about visiting the dentist.

If you have a specific dental issue that you would like to address with the dentist, please list:

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I agree that all of the information above is complete and correct to the best of my knowledge. I also agree to report any changes in my medical history to my dentist.

Patient/Guardian Signature: ______________________________ **Date:** ____________