

Medical History Update

Patient Name: _____

Family Physician's Name: _____ City: _____ Phone: (_____) _____

Preferred Pharmacy Information: _____ City: _____ Phone: (_____) _____

Have you had or currently have any of the following conditions?

Yes	No	Yes	No	Yes	No	Yes	No				
Heart Disease or Attack	<input type="checkbox"/>	<input checked="" type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stroke	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	AIDS or HIV Positive	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Artificial Joints (Hip, Knee)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input checked="" type="checkbox"/>			

Have you ever had surgery? Yes No If yes, list all past surgical procedures. _____

Do you have any disease, problem, or condition not listed? Yes No If Yes, what? _____

Are you currently under the care of a Physician? Yes No If Yes, why? _____

Are you currently taking any medications, drugs, pills, or multivitamins? Yes No If Yes, what? Please list below:

Do you have an allergy to local anesthetic? Yes No If Yes, what? _____

Do you have an allergy to any other medication(s)? Yes No If Yes, what? _____

Do you have an allergy to latex / rubber products/ metals? Yes No If Yes, what? _____

Have you ever had a prescription for Bisphosphonate (Fosamax)? Yes No

Are you taking a blood thinner (Coumadin, Warfarin)? Yes No

Do you use tobacco products (including vaping devices)? Yes No

FOR WOMEN ONLY: Are you pregnant? Yes No Are you taking Birth Control Pills? Yes No

Nearest Relative not living with you: _____ Relation: _____ Phone: (_____) _____

THE ABOVE INFORMATION IS TRUE: To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medication, I will inform the Doctor at the next appointment. If deemed advisable, I grant permission for my Physician to be contracted for details and advice.

X _____
Patient or Guardian Signature

X _____
Provider (Dentist/Hygienist) Signature

_____ Date

(For Office Use Only) Medical History Review: I have reviewed this medical history and have added any changes since my last review.

Initial: _____ Date: _____
Dr./Hygienist Initial: _____

Initial: _____ Date: _____
Dr./Hygienist Initial: _____

Initial: _____ Date: _____
Dr./Hygienist Initial: _____

OVER →



Airway Screening Questionnaire

905 Calle Amanecer, Suite 265
San Clemente, CA 92673
(949) 388-0780 OceanViewDentist.com
General & Cosmetic Dentistry

The latest biomedical research is uncovering the link between sleep-related breathing disorders (SRBD) and our overall health. The American Dental Association (ADA) Council on Dental Practice made a Policy Statement emphasizing the important role dental professionals play in screening and either treating or referring for sleep, breathing and airway related disorders. In compliance with ADA's position statement, we are providing this screening questionnaire to our patients.

Please check any of the following signs and symptoms that apply to you:

SLEEP/BREATHING:

<input type="checkbox"/> Snoring or Noisy Breathing	<input type="checkbox"/> Wake Up Unrefreshed	<input type="checkbox"/> Asthma Symptoms
<input type="checkbox"/> Pauses, Gasping or Choking	<input type="checkbox"/> Day-Time Drowsiness	<input type="checkbox"/> Bed Wetting (current or Past)
<input type="checkbox"/> Tossing or Kicking	<input type="checkbox"/> Nasal Breathing Issues	<input type="checkbox"/> CPAP Use (current or past)
<input type="checkbox"/> Nightly Awakenings	<input type="checkbox"/> Mouth Breathing	

<input type="checkbox"/> Crowded or Rotated Teeth	<input type="checkbox"/> Retruded or Small Jaw	<input type="checkbox"/> Swallow or Speech Issues
<input type="checkbox"/> Gaps Between Teeth	<input type="checkbox"/> "Gummy Smile"	<input type="checkbox"/> Chapped Lips, Dry Mouth
<input type="checkbox"/> Uneven Bite or Bite Issues	<input type="checkbox"/> Tongue or Lip Tie	

OCCLUSAL/OROFACIAL:

<input type="checkbox"/> Grinding or Clenching	<input type="checkbox"/> Jaw or Facial Pain	<input type="checkbox"/> Numbness in Hands, Arms
<input type="checkbox"/> Teeth Wear	<input type="checkbox"/> Jaw Clicking or Noise	<input type="checkbox"/> Neck or Shoulder Pain
<input type="checkbox"/> Gum Recession	<input type="checkbox"/> Ringing in the Ear	<input type="checkbox"/> Back or Pelvic Pain
<input type="checkbox"/> Teeth Sensitivity	<input type="checkbox"/> Locked or Limited Jaw	<input type="checkbox"/> Dizziness or Vertigo
<input type="checkbox"/> Headaches or Migraines		

TMJ/CRANIOFACIAL:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Acid Reflux (GERD)	<input type="checkbox"/> Problems with Learning
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fatigue or Tiredness	<input type="checkbox"/> ADHD or ADD
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Weight Issues	<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Lupus	<input type="checkbox"/> Problems with Memory	<input type="checkbox"/> Anxiety or Depression
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Problems with Focusing	

NEUROMUSCULAR / SYSTEMIC / PSYCHOSOCIAL:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Acid Reflux (GERD)	<input type="checkbox"/> Problems with Learning
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fatigue or Tiredness	<input type="checkbox"/> ADHD or ADD
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Weight Issues	<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Lupus	<input type="checkbox"/> Problems with Memory	<input type="checkbox"/> Anxiety or Depression
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Problems with Focusing	

If none of these symptoms apply to you, please check this box.

Patient Signature: _____

Date: _____

(For Office Use Only) Medical History Review: I have reviewed this medical history and have added any changes since my last review

Initial: _____ Date: _____
Dr./Hygienist Initial: _____

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Dr./Hygienist Initial: _____