

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 type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis	<input type="checkbox"/> <input type="checkbox"/>	Dry Mouth	<input type="checkbox"/> <input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>	Liver Disease	<input type="checkbox"/> <input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/> <input type="checkbox"/>
Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>	Emphysema	<input type="checkbox"/> <input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/> <input type="checkbox"/>	Chemotherapy	<input type="checkbox"/> <input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Heart Surgery	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>	Hemophilia	<input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV Positive	<input type="checkbox"/> <input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/>	Artificial Joints (Hip, Knee)	<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/> <input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/> <input type="checkbox"/>	Arthritis	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/>	Drug Addiction	<input type="checkbox"/> <input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/> <input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/> <input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/> <input 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 (Fosmax)? ☐ 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 | |

OCCCLUSAL/OROFACIAL:

- | | | |
|---|--|---|
| <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 | |

TMJ/CRANIOFACIAL:

- | | | |
|---|--|--|
| <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 | | |

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: _____

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