SWISS BIOLOGIC DENTISTRY
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swissbiologic.com

Medical and Dental History

Patient Name: ______________________________ Date of Birth: ______________

Physician name: ______________________________ Phone: ______________

Date of last physical exam: ______________ Are you currently under the care of a physician? ______________

If yes, please explain: ______________________________

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

Abnormal Bleeding ☐Yes ☐No
Acid Reflux ☐Yes ☐No
Alcohol Abuse ☐Yes ☐No
Allergies ☐Yes ☐No
Anemia ☐Yes ☐No
Angina Pectoris ☐Yes ☐No
Anorexia/ Bulimia ☐Yes ☐No
Arthritis ☐Yes ☐No
Artificial Bones ☐Yes ☐No
Artificial Heart ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No
Artificial Joints ☐Yes ☐No
Artificial Prosthesis ☐Yes ☐No
Asthma ☐Yes ☐No
Autoimmune Disorders ☐Yes ☐No
Bacterial Endocarditis ☐Yes ☐No
Blood Transfusion ☐Yes ☐No
Bruise Easily ☐Yes ☐No
Cancer ☐Yes ☐No
Chest Pain ☐Yes ☐No
Colitis ☐Yes ☐No
Congenital Heart Defect ☐Yes ☐No
Cortisone Medicine ☐Yes ☐No
Diabetes ☐Yes ☐No

Difficulty Breathing ☐Yes ☐No
Drug Abuse ☐Yes ☐No
Emphysema ☐Yes ☐No
Fainting Spells ☐Yes ☐No
Fever Blisters ☐Yes ☐No
Frequent Headache ☐Yes ☐No
Glaucoma ☐Yes ☐No
Hay Fever ☐Yes ☐No
Heart Attack ☐Yes ☐No
Heart Disease ☐Yes ☐No
Heart Failure ☐Yes ☐No
Heart Murmur ☐Yes ☐No
☐ *Physiological* ☐ *Functional* ☐ *Innocent*
Heart Surgery ☐Yes ☐No
Hemophilia ☐Yes ☐No
Hepatitis ☐Yes ☐No
☐*A* ☐*B* ☐ *C*
High Blood Pressure ☐Yes ☐No
HIV ☐Yes ☐No
AIDS ☐Yes ☐No
Kidney Disease ☐Yes ☐No
Kidney Problem ☐Yes ☐No
Liver Disease ☐Yes ☐No
Lyme Disease ☐Yes ☐No

Low Blood Pressure ☐Yes ☐No
Loss of Appetite ☐Yes ☐No
Loss of Sleep ☐Yes ☐No
Mitral Valve Prolapse ☐Yes ☐No
Regurgitation ☐*Yes* ☐*No*
MTHFR Gene Mutation ☐Yes ☐No
Obstructive Sleep Apnea ☐Yes ☐No
Osteoporosis ☐Yes ☐No
Pacemaker ☐Yes ☐No
Pain in jaw Joints ☐Yes ☐No
Pulmonary Shunts ☐Yes ☐No
Psychiatric Problems ☐Yes ☐No
Radiation Therapy ☐Yes ☐No
Rheumatic Fever ☐Yes ☐No
Seizures ☐Yes ☐No
Sickle Cell Disease ☐Yes ☐No
Sinus Problems ☐Yes ☐No
Stroke ☐Yes ☐No
Thyroid problems ☐Yes ☐No
Tobacco Use ☐Yes ☐No
☐*Chewing* ☐ *Smoking*
Tuberculosis ☐Yes ☐No
Ulcers ☐Yes ☐No
Venereal Disease ☐Yes ☐No
Yellow Jaundice ☐Yes ☐No

Are you allergic to any of the following medications?

Aspirin ☐Yes ☐No
Nitrous Oxide ☐Yes ☐No
Dental Anesthetics ☐Yes ☐No
Penicillin ☐Yes ☐No

Codeine ☐Yes ☐No
Clindamycin ☐Yes ☐No
Valium ☐Yes ☐No
Other: ______________

Sulfa ☐Yes ☐No
Latex ☐Yes ☐No
Metals ☐Yes ☐No

List any medicines you are currently taking: ______________________________

Are you currently taking bisphosphanates **OR** have you taken any in the past like Reclast, Boniva, Actonel, Fosamex, Prolia, etc: ☐Yes ☐No

Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No

(continued)

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If you have been diagnosed with cancer, what kind was it, when was it diagnossed, and what was the treatment:______________________
____
____

If you have artificial joints, what kind is it, when was the surgery, and was there any infection:______________________________________
____

Is there any other medical information not included above which you feel we should be informed about? ☐ Yes ☐ No

If yes, please explain: ____

What prompted you to seek dental care at this time? ____

How long has it been since your last thorough dental examination?____

When were your teeth last cleaned? ____________________________________ X-rayed? _______________________________________

Have you had any previous periodontal therapy? If yes, please list the provider and dates: ____

____

Have you had any bad experiences in a dental office? ____

If yes, please explain: ____
____

Are you troubled with bad breath?	☐ Yes	☐ No
Do you experience excessive dry mouth?	☐ Yes	☐ No
Do your gums bleed easily, feel tender or irritated?	☐ Yes	☐ No
Are there areas in your mouth where food sticks or get caught?	☐ Yes	☐ No
Are you self-conscious about the appearance of your teeth?If yes, please explain: ________________________________	☐ Yes	☐ No
Do your jaws feel tired or sore?	☐ Yes	☐ No
Do you experience excessive headaches and/or pain in the neck, shoulders or back?	☐ Yes	☐ No
Do you experience clicking or popping noises when opening or closing your mouth, or when chewing?	☐ Yes	☐ No
Are you aware of grinding or clenching your teeth?	☐ Yes	☐ No
Do you use any tobacco products?	☐ Yes	☐ No
Do you snore or experience breathing difficulties at night?	☐ Yes	☐ No
Do you currently wear any type of oral appliance?	☐ Yes	☐ No
Do you experience day-time fatigue?	☐ Yes	☐ No
Do you wake up one or more times during the night?	☐ Yes	☐ No

What, if anything, would you do to change the appearance of your teeth? ____
____

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize Swiss Biologic Dentistry and/or their trained staff to take X-rays, study models, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Swiss Biologic Dentistry and/or their trained staff to present my treatments needed according to their findings. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

____ _________________
Signature of Patient/Parent or Guardian Date

____ _________________
Reviewed By Date

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