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Delight Dental Studio Medical History Form

We want to take care of your concerns and needs

First Name _________________________ Last Name _________________________ Birth Date _______________________

Reason for Today's Visit (Please Check All That Applies)

☐ Regular Checkup & Cleaning ☐ Tooth Pain ☐ Broken Tooth ☐ Whitening ☐ Invisalign

☐ Bleeding Gums ☐ Bad Breath ☐ Sensitive Teeth ☐ Loose Teeth ☐ Growth in Mouth

☐ Jaw Pain ☐ School Exam ☐ Medical Clearance ☐ Food Collection Between Teeth

Please explains if there are other concerns ____

Date of Last Dental Exam Taken ______________ Date of Last X-ray Taken ________________

X-ray Taken Less than 6 Months ☐ Yes ☐ No If yes, do you have X-rays available for your visit today? ☐ Yes ☐ No

Why did you leave your last dentist? ____

Does dental treatment make you nervous? ☐ Yes ☐ No

Any problem with previous dental treatment? ____

Emergency Contact Information

Are you currently under physician's care? ☐ Yes ☐ No Please Describe____

Name of Your Current Medical Doctor_______________________ Phone ______________ City / State__________________

Emergency Contact ____________________________________ Phone _______________ Relationship_________________

Medication / Allergy

List all medications that you currently take. If you don't take any, please type "None"

1. __________________________________
2. __________________________________
3. __________________________________
4. __________________________________
5. __________________________________
6. __________________________________
7. __________________________________
8. __________________________________
9. __________________________________
10. __________________________________

Are you allergic to anything? ☐ **Yes** ☐ **No** **If yes, please check all allergy that applies to you.**

Y	N		Y	N	
☐	☐	Local Anesthetics	☐	☐	Sulfa
☐	☐	Aspirin	☐	☐	Morphine
☐	☐	Codeine	☐	☐	Keflex or Other Cephalosporin
☐	☐	Ibuprofen, Naproxen, or NSAIDS	☐	☐	Penicillin or Amoxicillin
☐	☐	Iodine	☐	☐	Other Food or Environmental Allergies
☐	☐	Latex	☐	☐	Other Drug Allergies

Medical History

Do you have or had any of the following medical conditions? Please check all that applies.

Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Heart Surgery
☐	☐	Anaphylaxis	☐	☐	Hemophilia
☐	☐	Anemia	☐	☐	Hepatitis
☐	☐	Arrhythmia	☐	☐	HIV Positive / AIDS
☐	☐	Arthritis	☐	☐	High Blood Pressure
☐	☐	Artificial Joints	☐	☐	Kidney Failure or Dialysis
☐	☐	Artificial Heart Valves	☐	☐	Liver Disease
☐	☐	Asthma	☐	☐	Lupus
☐	☐	Autoimmune Disease	☐	☐	Low Blood Pressure
☐	☐	Back Problems	☐	☐	Nervousness / Anxiety / Panic Attack
☐	☐	Blood Transfusion	☐	☐	Organ Transplant
☐	☐	Cancer / Chemotherapy / Radiation Treatment	☐	☐	Pacemaker or Defibrillator
☐	☐	Congenital Heart Defect	☐	☐	Rheumatic Fever
☐	☐	COPD or other Respiratory Disease	☐	☐	Sinus Problems
☐	☐	Cortisone Treatments or Chronic Steroid Usage	☐	☐	Sickle Cell Disease
☐	☐	Depression/Bipolar	☐	☐	Smoking
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Drug or Alcohol Dependency	☐	☐	Sexually Transmitted Disease
☐	☐	Epilepsy / Seizures	☐	☐	Thyroid Disease
☐	☐	Fainting	☐	☐	Tuberculosis
☐	☐	Glaucoma	☐	☐	Ulcer / Colitis
☐	☐	Heart Attack	☐	☐	Others ___________________________________

(Women Only) Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pill? ☐ Yes ☐ No

Please let us know if there's anything else we should know to better serve you.