82204 Hwy 111 Suite A
Indio, CA 92201
(760) 775-5552

50249 Cesar Chavez St Suite G
Coachella, CA 92236
(760) 398-9848

30877 Date Palm Dr. Suite B4
Cathedral City CA 92234
(760) 202-7400

31500 Grape St Suite 8
Lake Elsinore CA 92532
(951)471-2834

Medical History

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Name and phone number of your physician:

_____

_____

Name and phone number of your preferred pharmacy:

_____

_____

Indicate which of the following conditions are active or current.
By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Cong Heart Failure
- ☐ Embolia
- ☐ Glaucoma
- ☐ Heart Valve Implant
- ☐ HIV/AIDS
- ☐ iodine
- ☐ Low Blood Pressure
- ☐ mercury
- ☐ Nervous Disorders
- ☐ PCN
- ☐ Respiratory Problems
- ☐ Shunt
- ☐ Thyroid
- ☐ Ulcers
- ☐ *Pre-Med - Clind
- ☐ Allergy - Ativan
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Hyper thyroid
- ☐ Jaundice
- ☐ Lupus
- ☐ Metal Implants
- ☐ Open Heart Surgery
- ☐ Penicillin
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ *Pre-Med - Other
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Antibiotics
- ☐ Asthma
- ☐ Cholesterol
- ☐ Dialysis
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Herpes
- ☐ Hypo Thyroid
- ☐ Kidney Disease
- ☐ Menopenem
- ☐ Motrin
- ☐ Other
- ☐ Pneumonia
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Tumors
- ☐ Allergies
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Anxiety
- ☐ Autism
- ☐ Codeine
- ☐ Dizziness
- ☐ Fainting
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Ibuprofen
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Naproxen
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Tylenol

- ☐ Recent Hospitalization
- ☐ FEMALE: Taking Birth Control Pills
- ☐ Alcohol Use
- ☐ FEMALE: Currently Pregnant/Possibly Pregnant
- ☐ Tobacco/Vape Use
- ☐ Recreational Drugs
- ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe:

Have you ever been instructed to take antibiotic premedication for your dental visits? If yes, please explain: * ◯ Yes ◯ No

Pre Med:

Describe any current or past medical treatment or impending surgery.

Are you currently taking or have you ever taken bone denisty medication (Bisphosphonates) such as Boniva, Fosamax, Didronel, Zometa, Actonel, etc? If yes, please describe below

◯ Yes ◯ No

Bisphosphonate

Are you currently taking any blood thinner medications including daily doses of aspirin? ◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

Provider notes

Dental History

Previous Dentist and phone number

Date of last dental exam and x-rays

I routinely see my Dentist every

◯ 3 months ◯ 6 months ◯ Yearly ◯ Not routinely

What is your immediate concern or chief complaint?

Is there anything about the appearance of your smile you would want to change?

Check all that apply

- ☐ Difficulty getting numb
- ☐ Experience dry mouth
- ☐ Food gets trapped between teeth
- ☐ Difficulty chewing
- ☐ Gums bleed when brushing or flossing
- ☐ Notice an unpleasant taste or odor in mouth
- ☐ Experience a burning sensation in mouth
- ☐ Reaction to local anesthetic
- ☐ Teeth sensitive to hot, cold, biting, sweets
- ☐ Whitened or bleached teeth
- ☐ Clench or grind teeth
- ☐ Treated for gum disease
- ☐ Experienced gum recession
- ☐ Snore or wake up frequently during the night
- ☐ Had/have braces, orthodontic treatment
- ☐ Avoid brushing any part of mouth
- ☐ Popping and/or clicking of jaw joint
- ☐ Wear or have worn a bite appliance
- ☐ Were told you have lost bone around your teeth
- ☐ Loose teeth on their own (without injury)
- ☐ Complications from past dental treatment

If any of the above checkboxes need further clarification, please explain

Provider notes

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Response Date: _____