

Medical History Update

Patient Name: _____ Date: _____

Recent research indicates a strong relationship between the mouth and the body. Since we now know how closely they are related, we are going to be asking you some questions about your family history and your overall health that we may not have asked you about before. This additional information will assist us in providing the best possible care to maintain your oral health and overall wellness.

1. Any changes in your health since your last dental visit? ☐ Yes ☐ No If yes, please list: _____

2. What medications are you taking? _____

3. Any changes in medication dosage or medications? ☐ Yes ☐ No If yes, please list: _____

4. What over the counter or supplements are you taking on a regular basis? Please list: _____

5. Does your mouth frequently feel dry? ☐ Yes ☐ No If yes, on a scale of 1 to 10, how much does it disrupt your daily activities? _____

6. Do you smoke, vape, use nicotine pouches, cannabis products or any other smokeless tobacco products? Yes ☐ No ☐
if yes, please list: _____

7. Are you taking any bisphosphonates in the past or presently? Yes ☐ No ☐ If yes, please provide details: _____

8. Do you have a persistent sore throat/infection, hoarseness, earache or feeling of something being caught in your throat? _____

☐ Yes ☐ No If yes, please provide details: _____

9. Have you ever been diagnosed with a high-risk strain HPV infection? Yes ☐ No ☐

10. Have you had the HPV vaccination? Yes ☐ No ☐ If yes, how many years ago? _____

11. Have you had any surgery or been hospitalized since your last visit? Yes ☐ No ☐

If yes, please explain: _____

12. Are you being treated for any medical problem presently? Yes ☐ No ☐

If yes, please explain: _____

13. Have you ever taken antibiotics prior to having your teeth cleaned or before dental work? Yes ☐ No ☐

If yes, please explain: _____

14. Any allergies to drugs, food, metal or latex? Yes ☐ No ☐

If yes, please list: _____

15. History of illness or disease in family such as cardiovascular disease, diabetes, autoimmune disease? _____

If yes, please explain: _____

16. Have you been diagnosed with osteoarthritis or rheumatoid arthritis? Yes ☐ No ☐

17. Have you experienced increased joint pain or decrease in mobility? Yes ☐ No ☐

18. Are you taking a form of collagen supplementation? Yes ☐ No ☐

19. Have you been diagnosed with diabetes? ☐ Type I ☐ Type II ☐ Pre-diabetes

☐ Diet-controlled ☐ Medication controlled Under control: Yes ☐ No ☐

20. Have you had any heart problems or a knee, hip or prosthetic joint replacement? Yes ☐ No ☐

If yes, provide details: _____

21. Have you had a bone mineral density test? Yes ☐ No ☐ Results: _____

22. Female clients; Are you pregnant? ☐ Yes ☐ No

23. On a scale of 1 to 10 (1 being poor/10 being healthy), how would you rate your general health at this time? _____

24. How would you rate your level of stress presently? Low ☐ Moderate ☐ High ☐

25. On a scale of 1 to 10 (1 being poor/10 being excellent), how would you rate your quality of sleep at this time? _____

26. On a scale of 1 to 10 (10 being highest), how closely related is the health of your mouth to your overall health in your opinion? _____