



STEDDUM

FAMILY & RESTORATIVE
DENTISTRY

Patient Information, Medical and Dental History

Patient Information

Full Name: _____ DOB: _____ SSN: _____

Street Address (include City, State, Zip Code): _____

Mobile Phone: _____ Work Phone: _____ eMail: _____

In Case of Emergency Contact: _____ Relationship: _____ Phone: _____

Medical History

Primary Care Physician (Name and Address): _____

Preferred Pharmacy (Name and Address): _____

List any medications you are currently taking including non-prescription drugs, vitamins, supplements, etc: _____

List any Allergies: _____

Have you had any surgeries? If yes, please list: _____

Have you ever been hospitalized? If yes, please explain: _____

	No	Yes		No	Yes		No	Yes		No	Yes
HIV+/AIDS	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Rheumatic Fever	☐	☐
Alcoholism	☐	☐	Epilepsy	☐	☐	Kidney Dialysis	☐	☐	Rheumatism	☐	☐
Allergies	☐	☐	Glaucoma	☐	☐	Latex Sensitivity	☐	☐	Scarlet Fever	☐	☐
Anemia	☐	☐	Hay Fever	☐	☐	Lupus	☐	☐	Seizures/Fainting	☐	☐
Arthritis	☐	☐	Head Injuries	☐	☐	Low Blood Pressure	☐	☐	Sinus Problems	☐	☐
Asthma	☐	☐	Hearing Impaired	☐	☐	Malignancies	☐	☐	Stomach Ulcers	☐	☐
Blood Disease	☐	☐	Heart Disease	☐	☐	Mitral Valve Prolapse	☐	☐	Stroke	☐	☐
Bone Disease	☐	☐	Heart Murmur	☐	☐	Neck & Back Pain	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	Hepatitis/Liver Disease	☐	☐	Nervous Disorders	☐	☐	Tuberculosis	☐	☐
Chemical Dependence	☐	☐	Hepatitis Virus	☐	☐	Pacemaker	☐	☐	Tumors/Growths	☐	☐
Chest Pain	☐	☐	High Blood Pressure	☐	☐	Prosthetics	☐	☐	Ulcers	☐	☐
Circulation Problems	☐	☐	HPV	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
Convulsions/Seizures	☐	☐	Jaundice	☐	☐	Radiation Treatment	☐	☐		☐	☐
Diabetes	☐	☐	Joint Replacement	☐	☐	Respiratory Problems	☐	☐			

Do you have any medical problems that are not reported above? _____

Have you had an organ transplant and/or are you taking immune suppressing medication? ☐ No ☐ Yes

Do you smoke, vape, or use smokeless tobacco? ☐ No ☐ Yes

Do you use recreational drugs? ☐ No ☐ Yes

Have you ever taken medications such as Fosamax, Boniva, Reclast, etc. for treatment of osteoporosis, or bone cancer? ☐ No ☐ Yes

If yes to any above, describe: _____



STEDDUM

FAMILY & RESTORATIVE
DENTISTRY

Patient Information, Medical and Dental History (Continued)

Dental History

Please select your primary reason for this dental appointment: ☐ Dental Check-up ☐ Cleaning ☐ Esthetic Consultation

☐ TMJ Botox ☐ Emergency ☐ Other (Please Describe): _____

When was your last dental check-up and cleaning? _____

	No	Yes		No	Yes
Do your gums bleed?	☐	☐	Do you have any ulcers or growths in your mouth?	☐	☐
Do you clench or grind your teeth?	☐	☐	Are you pleased with the appearance of your teeth?	☐	☐
Do you have clicking or popping in your jaw?	☐	☐	Do you feel confident in your smile?	☐	☐
Do you have jaw-joint pain/discomfort?	☐	☐	Do you have any emotional concerns about your dental care?	☐	☐
Do you notice cracks in your teeth?	☐	☐	Would you like sedation for dental care?	☐	☐

Is there anything you would like to share that will help us provide the best dental experience possible? _____

Patient Name (Print)

Signature of Patient or Legal Representative

Date

Doctor's Signature

Date