LANDMARK TOTAL DENTISTRY
MEDICAL/DENTAL HEALTH HISTORY

Name: ____

Physician's Name: ____Date of last exam:

Previous Dentist: ____Date of last exam:

Do you want us to request your dental records? Yes____ No____ If yes, please provide Tel.#, Address or Email:

	Yes	No		Yes	No		Yes	No
AIDS/HIV			Heart Disease/Surgery			Osteoporosis		
Anemia			Heart Murmur or Defect			I.V. Aredia,Reclast, Zometa Fosamax, Actonel, Boniva Other Bisphosphonates		
Arthritis, Rheumatism			Angina/Chest Pain					
Artificial Heart Valves			Heart Attack/Failure					
Artificial Joints			Congenital Heart Disorder			Dental Implants		
Asthma			Mitral Valve Prolapse			Arthritis/Gout		
Back Problems			Scarlet Fever			Rheumatism		
Bleeding or Clotting Problems			Rheumatic Fever			Pain in Jaw Joint		
Blood Diseases			Artificial Heart Valve			Popping or Clicking in Jaw Joints		
Cancer			Heart Pace Maker			Artificial Joints/Date Placed: __________		
Chemical Dependency			Pulmonary Shunt			Need Premedication		
Chemotherapy			High Blood Pressure			Respiratory Disease		
Circulatory Problems			Low Blood Pressure			Hepatitis/Jaundice		
Cochlear Implants			History of Bacteria Endocarditis			Kidney Problems		
Cortisone Treatments			Unexplained Fever			Renal Dialysis		
Cough, persistent or bloody			Bruise Easily			Sexually Transmitted Disease		
Diabetes			Coronary Stent			Genital Herpes		
Hypoglycemia			Swelling of limbs			Drug Addition/Alcoholism		
Excessive Bleeding			Lung Disease			Recent Blood Transfusion		
Sickle Cell Disease			Shortness of Breath			Sleep Apnea		
Hemophilia			Frequent Cough			Psychiatric Care		
Leukemia			Hay Fever/Sinus Problems			Night Sweats		
Recent Blood Transfusion			Thyroid Disease			Depression		
X-ray/Radiation Treatment			Stroke			Nervousness		
Tumors or Growths			Convulsions			Alzheimer's Disease		
Tuberculosis			Epilepsy or Seizures			Recent Weight Loss		
Emphysema			Fainting or Dizziness			Hives or Rash i.e. Latex		
Glaucoma			Ulcers			Allergies or Reactions to Medicine		
Do you Wear Contact lenses			Tobacco cigarettes					
Are you Pregnant			Tobacco chew			If yes to allergies please list:		
Are you Nursing			Marijuana					
Are You Taking Birth Control Pills			CBD oil					

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?			Do you have frequent headaches?		

Question			Question		
Are your teeth sensitive to hot or cold liquids/foods?			Do you clench or grind your teeth?		
Are your teeth sensitive to sweet or sour liquids/foods?			Have you ever been diagnosed with gum disease?		
Do you feel pain in any of your teeth?			Have you ever had any difficult extractions in the past?		
Do you have any sores or lumps in or near your mouth?			Have you ever had any prolonged bleeding following extractions?		
Have you had any head, neck or jaw injuries?			Have you ever had orthodontic treatment?		
Have you ever experienced any of the following problems in your jaw?			Do you wear dentures or partials? If yes, date of placement: ___________________________________		
Clicking			Have you ever received instructions regarding the care of your teeth and gums?		
Pain (joint, ear, side of face)			Do you like your smile?		
Difficulty opening or closing			Reason for today's appointment:		
Difficulty in chewing					

Hospitalizations/Surgeries

Please provide dates, diagnosis, procedures:

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Medications

Please list any medications you are currently taking and the correlating diagnosis (The condition for which you are taking each medication):

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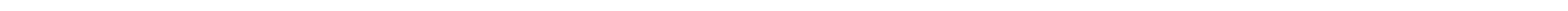
Pharmacy Name: ____

Phone: ____

Are there any health conditions you feel were not covered in this questionnaire that you wish to discuss?



Authorization and Release

I certify that I have read and understand the Medical and Dental Histories to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child or dependent during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Per Reiakvam insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

Date: ______________

Signature of patient (or parent/guardian if minor): ____