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		
Arthritis, Rheumatism			Angina/Chest Pain			Fosamax, Actonel, Boniva		
Artificial Heart Valves			Heart Attack/Failure			Other Bisphosphonates		
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			Tuberculosis		
Circulatory Problems			Low Blood Pressure			Respiratory Disease		
Cochlear Implants			History of Bacteria Endocarditis			Hepatitis/Jaundice		
Cortisone Treatments			Unexplained Fever			Kidney Problems		
Cough, persistent or bloody			Bruise Easily			Renal Dialysis		
Diabetes			Coronary Stent			Sexually Transmitted Disease		
Hypoglycemia			Swelling of limbs			Genital Herpes		
Excessive Bleeding			Lung Disease			Drug Addition/Alcoholism		
Sickle Cell Disease			Shortness of Breath			Recent Blood Transfusion		
Hemophilia			Frequent Cough			Sleep Apnea		
Leukemia			Hay Fever/Sinus Problems			Psychiatric Care		
Recent Blood Transfusion			Thyroid Disease			Night Sweats		
X-ray/Radiation Treatment			Stroke			Depression		
Tumors or Growths			Convulsions			Nervousness		
Tuberculosis			Epilepsy or Seizures			Alzheimer's Disease		
Emphysema			Fainting or Dizziness			Recent Weight Loss		
Glaucoma			Ulcers			Hives or Rash i.e. Latex		
Do you Wear Contact lenses			Tobacco cigarettes			Allergies or Reactions to Medicine		
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?		
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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medications

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

_____
_____
_____
_____
_____
_____
_____

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): _____