John L. Smith, DDS, MS

Patient health history

1 | About you and your health

Complete all three pages. Bring this form to your visit or email it to drsmith@johnsmithdds.com beforehand. Ask us about unclear questions; attach extra pages if needed.

Full name

Date of birth

Today's date

Phone

Email (optional)

Emergency contact name

Emergency contact phone

Relationship

Primary physician / treating specialist(s)

Physician phone(s)

Medical history - past or current

Have you ever been diagnosed with any of the following? Select one answer per row.

	Yes	No	Not sure		Yes	No	Not sure
Heart disease / heart attack	○	○	○	Liver disease / hepatitis	○	○	○
High blood pressure	○	○	○	Thyroid disease	○	○	○
Heart valve disease / artificial valve	○	○	○	Seizures / epilepsy	○	○	○
Infective endocarditis	○	○	○	Autoimmune disease / immune disorder	○	○	○
Abnormal heart rhythm / pacemaker	○	○	○	Cancer / chemotherapy / radiation	○	○	○
Stroke / TIA	○	○	○	HIV or another immune deficiency	○	○	○
Bleeding or blood-clotting disorder	○	○	○	Osteoporosis / other bone disease	○	○	○
Diabetes	○	○	○	Artificial joint / joint replacement	○	○	○
Asthma / COPD / breathing disorder	○	○	○	Tuberculosis	○	○	○
Sleep apnea / CPAP use	○	○	○	Mental health condition	○	○	○
Kidney disease / dialysis	○	○	○	Chronic pain condition	○	○	○

Explain Yes / Not sure answers, other conditions, current care, and recent surgery or hospital stays (with dates).

Patient health history

Patient name

Date of birth (MM/DD/YYYY)

Medicines and supplements

List all prescriptions, over-the-counter medicines, vitamins, and supplements. Include diabetes / weight-loss medicines (including GLP-1 medicines), blood thinners, steroids, and pain medicines.

☐ I take no medicines or supplements ☐ Current medication list attached

Name	Dose	How often	Reason

Allergies and reactions

☐ No known allergies ☐ Not sure

Include medicines, latex, adhesives, metals, foods, and any prior allergic reactions.

Substance / medicine	Reaction and severity

Select one answer for each question below.

Ever used bone-strengthening medicines (e.g., Fosamax, Prolia, Reclast)? ◯ Yes ◯ No ◯ Not sure

Ever been told to take antibiotics before dental treatment? ◯ Yes ◯ No ◯ Not sure

Any personal or family problems with anesthesia or sedation? ◯ Yes ◯ No ◯ Not sure

If Yes / Not sure: medicine names and dates, condition, or reaction (attach a page if needed)

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Patient health history

3 | Dental concerns, health factors, and review

Patient name

Date of birth (MM/DD/YYYY)

What brings you in? What would you like help with?

General dentist / office

Last dental exam / cleaning (date)

Current concerns - check all that apply

- ☐ Bleeding / swollen gums
- ☐ Receding gums
- ☐ Pain / sensitivity
- ☐ Loose teeth / bite change
- ☐ Implant concern
- ☐ Missing teeth
- ☐ Clenching / grinding / jaw pain
- ☐ Dry mouth / bad breath
- ☐ Mouth sore / lump

Previous deep cleaning, gum surgery, implants, or dental complications (include dates and healing problems)

Tobacco / nicotine (including vaping) ◯ Never ◯ Former ◯ Current

If former / current: type, amount, years used, and quit date if applicable

Alcohol, cannabis, or other nonprescribed substances: type, amount, frequency (write None, or Discuss privately)

Pregnant, possibly pregnant, or breastfeeding? ◯ Yes ◯ No ◯ Not sure ◯ N/A

If applicable: details / due date

Dental anxiety, access needs, or anything else to discuss

Patient confirmation

I have answered to the best of my knowledge. I will tell the dental team about changes to my health or medicines. This health history is not consent to treatment.

Patient / parent / guardian signature (type name or sign)

Date

If signed by someone else: name and relationship

Office use: reviewed by / date / follow-up needed