

# Vibe Huntsville

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## Medical History Form

### Patient Information

Name : \_\_\_\_\_  
Gender : \_\_\_\_\_  
DOB : \_\_\_\_\_  
Phone : \_\_\_\_\_

Conditions			
Acid Reflux	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
ADHD Meds	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
AIDS	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Alzheimer's	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Anemia	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Arthritis	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Artificial Joints	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Asthma	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Autism spectrum	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Autoimmune disease	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Cancer	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Chemical Dependency	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Coumadin/Plavix/Aspr	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Diabetes	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Epilepsy	Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>

Glaucoma	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Head Injuries	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Hearing Impaired	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Heart Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Hepatitis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
High Blood Pressure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
High Cholesterol	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Jaundice	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Kidney Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Liver Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Low Blood Pressure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Low Cholesterol	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Mental Disorders	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Neurological Disorder	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
No NSAIDS	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Ortho	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Pacemaker	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Pain patient	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
who is your doctor and what clinic						
Pregnancy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>

Pre-med	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Prolonged Bleeding	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Psychiatric Care	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Radiation Treatment	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Respiratory Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Rheumatism	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Sinus Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Sleep apnea	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Do you use a sleep apnea appliance						
Is your sleep apnea well controlled?						
Stomach Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Stroke	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
suboxone	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Thyroid Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Tuberculosis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Tumors	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Ulcers	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Venereal Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
Other Conditions						

<b>Allergies</b>						
Aspirin	Yes		No		Don't Know	

Yes  No  Don't Know

Bisphosphonates

Yes  No  Don't Know

Codeine

Yes  No  Don't Know

Latex

Yes  No  Don't Know

Penicillin

Yes  No  Don't Know

Sulfite

Yes  No  Don't Know

Other Allergies

## Current Medications

Medication Name	Start Date	End Date

## Medical Questionnaire

Are you under the care of a physician?

Yes

No

Please give us the doctors names and phone numbers from the question above.

Are you in good health?

Yes

No

Are there any conditions that you are being treated for?

Date of your last physical exam with blood work?

Have you had a serious illness, operation or been hospitalized since your last visit. (If this is your first visit: in the past 5 years)

Yes

No

If you answered yes above, please tell us the reason.

Are you currently taking any medications? (prescription, over the counter, etc)

Yes

No

Please list all medications you are taking and dosages. (Including vitamins, natural or herbal preparations, and/or dietary supplements)

Do you wear contact lenses?

Yes

No

Anything else you think we should know about or you would like to talk about?

Tobacco use ( Smoke, Vape, Dip, Nicotine pouch)

Yes

No

How much in a day?

Do you drink alcohol?

Yes

No

How much in a day?

### Dental Questionnaire

Do your gums bleed when you brush or floss?

Yes

No

Are any of your teeth sensitive to sweets?

Yes

No

Are any of your teeth sensitive to hot or cold?

Yes

No

Are any of your teeth sensitive to pressure?

Yes

No

Have you ever had any periodontal (gum) treatments ( ex. deep cleaning)

Yes

No

Do you suffer from dry mouth?

Yes

No

Have you ever had orthodontic treatment?

Yes

No

Are you currently interested in orthodontic treatment?

Yes

No

Maybe

Have you ever had any problems associated with previous dental treatment?

Yes

No

If you answered yes above please explain what the problem was.

Is your home water supply fluoridated?

Yes

No

Do you drink bottled or filtered water?

Yes

No

How often do you drink soda, sport drinks or sugary drinks?

Multiple times a day

Once a day

Rarely

Never

Do you have frequent earaches or neck pain?

Yes

No

Sometimes

Do you have any clicking, popping or discomfort in the jaw?

Yes

No

Sometimes

Do you (or have you been told that you) grind your teeth?

Yes

No

Sometime

Do you have, or do you get sores or ulcers in your mouth?

Yes

No

Sometimes

Do you have or do you get sores on your lips?

Yes

No

Sometimes

Do you wear (or have worn) dentures or partials?

Yes

No

In the past

Do you participate in recreational activities that could result in trauma to the mouth or teeth? (ex. basketball, football, ...)

Yes

No

Sometimes

Have you ever had a serious injury to your head or mouth?

Yes

No

Date of last dental exam:

What was done at that last dental exam?

How do you feel about your smile? Is there something you would like to change or discuss with us?

What is the reason for your visit today?

**By signing below, I certify that all the above information is true to the best of my knowledge. I understand the importance of this information and that the practice will rely on this information for the treatment. I will not hold the practice or any member / staff of the practice, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.**

Signature of Patient or Responsible Party

Signed on

Signature of Provider

Signed on