

MB Dental Health History Form 2026

Patient Name:

Birth Date:

Date Created:

Your complete oral health is our main concern. Communication is key to helping us give you a happy, healthy smile. Because of this, we ask that you complete this form in its entirety.

Are you under the care of a physician? If yes, what is the date of your most recent physical examination? Yes No If yes

Have you ever been hospitalized for illness or injury? If yes, please specify: Yes No If yes

Are you allergic to any of the following?

- Aspirin Sulfa Iodine Fruit
Penicillin Local Anesthetic Metals (nickel, gold, silver) Milk
Erythromycin Fluoride Latex Red Dye
Tetracycline Chlorhexidine (CHX) Nuts

Do you have, or have you ever had:

- Heart problems in the last 6 months Cardiac stent in the last 6 months History of infective Endocarditis
Artificial heart valve, repaired defect Pacemaker or implantable defibrillator Orthopedic soft tissue implant
Heart murmur, rheumatic or scarlet fever High blood pressure Low Blood Pressure
Stroke (taking blood thinners) Anemia or other blood disorder Prolonged bleeding due to a slight cut
Pneumonia/Emphysema/Sarcoidosis Chronic ear infections or Tuberculosis Measles or Chicken Pox
Breathing problems (e.g. asthma) Sleep problems (e.g. sleep apnea) Kidney disease
Liver disease or jaundice Vertigo (e.g. the room is spinning) Thyroid/Parathyroid Disease
Hormone deficiency or imbalance High cholesterol or taking statin drugs Diabetes
Stomach or duodenal ulcer Digestive or eating disorder Osteoporosis/Osteopenia
Ever taken meds containing biphosphonate Arthritis or gout Autoimmune disease
Glaucoma Contact lenses Head or neck injuries
Epilepsy, convulsions (seizures) Neurologic disorders (i.e. Alzheimer's) Viral infections and cold sores
Lumps or swelling in the mouth Hives, skin rash, hay fever STI/STD/HPV
Hepatitis A Hepatitis B or C HIV/AIDS
Tumor, abnormal growth Radiation therapy Chemotherapy, immunosuppressive meds
Concentration problems or ADD/ADHD Alcohol/recreational drug use

Are you:

- Presently being treated for any illness Aware of a change in health in the last 24 hours
Taking medication for weight management Taking dietary supplements
Often exhausted or fatigued Experiencing frequent headaches
A smoker or smoked previously Considered a touchy/sensitive person
Often unhappy or depressed Taking birth control pills
Currently pregnant or trying Diagnosed with a prostate disorder
Experiencing chronic pain

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (i.e. Botox, Collagen Injections)

Empty text box for medical treatment details.

List all medications, supplements, vitamins, and/or probiotics taken within the last two years, and their purpose:

Empty text box for medication and supplement history.