

HOUSE FAMILY DENTISTRY PATIENT MEDICAL AND DENTAL HISTORY

Because your mouth is an important part of your entire body, health problems and allergies that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions and keeping us informed of any changes.

PATIENT NAME: _____ AGE: _____ DATE: _____

REASON FOR TODAY'S VISIT:

LAST DENTAL EXAM DATE: _____

DATE OF LAST DENTAL X-RAYS: _____

FORMER DENTIST: _____

MEDICAL HISTORY INFORMATION

FAMILY PHYSICIAN: _____

PHONE NUMBER: _____

EMERGENCY CONTACT: _____

PHONE NUMBERS: _____

CHECK YES OR NO TO THE FOLLOWING ITEMS.

- YES NO-----BROKEN FILLING(S)
- YES NO-----BURNING SENSATION ON TONGUE
- YES NO-----CHEW ON ONE SIDE OF MOUTH
- YES NO-----CLENCH OR GRIND TEETH
- YES NO-----CLICKING OR POPPING JAW
- YES NO-----DRY MOUTH
- YES NO-----FINGERNAIL BITING
- YES NO-----FOOD COLLECTION BETWEEN TEETH
- YES NO-----HEADACHES
- YES NO-----JAW PAIN OR TENDERNESS
- YES NO-----LIP OR CHEEK BITING
- YES NO-----LOOSE TEETH
- YES NO-----MOUTH BREATHING
- YES NO-----MOUTH PAIN WITH BRUSHING
- YES NO-----ORTHODONTIC TREATMENT
- YES NO-----PAIN AROUND EAR
- YES NO-----PERIODONTAL TREATMENT
- YES NO-----PROLONGED BLEEDING AFTER EXTRACTION(S)
- YES NO-----SENSITIVITY TO COLD
- _____
- YES NO-----SENSITIVITY TO HEAT
- _____
- YES NO-----SENSITIVITY TO SWEETS
- _____
- YES NO-----SENSITIVITY TO BITING PRESSURE
- _____
- YES NO-----SORES/GROWTHS IN MOUTH
- YES NO-----SWOLLEN, SORE, BLEEDING GUMS
- YES NO-----THUMB SUCKING
- YES NO-----REACTION/ALLERGY TO NOVOCAINE
- YES NO-----USE TOBACCO PRODUCTS
- YES NO-----UNPLEASANT TASTE/BAD BREATH
- YES NO-----HAVE EVER USED FEN-PHEN/REDUX
- YES NO-----HAVE EVER TAKEN FOSOMAX
- YES NO-----ALLERGIC TO MILK PRODUCTS

HOW OFTEN DO YOU BRUSH? _____

HOW OFTEN DO YOU FLOSS? _____

ARE YOU HAPPY WITH YOUR SMILE? _____

LIST ALL ALLERGIES

CURRENT MEDICATIONS

REASON

- YES NO-----ANEMIA
- YES NO-----ASTHMA
- YES NO-----AIDS/HIV
- YES NO-----ARTIFICIAL HEART VALVE _____
- YES NO-----ARTIFICIAL JOINT(S) _____
- YES NO-----BACK OR NECK PROBLEMS
- YES NO-----BIRTH CONTROL MEDICINE
- YES NO-----BLEEDING ABNORMALITIES
- YES NO-----BLOOD DISEASE(S)
- YES NO-----CANCER _____
- YES NO-----CHEMICAL DEPENDENCY
- YES NO-----CHEMOTHERAPY TREATMENT
- YES NO-----CIRCULATORY PROBLEMS
- YES NO-----CONGENITAL HEART PROBLEMS
- YES NO-----COPD
- YES NO-----CORTISONE TREATMENT _____
- YES NO-----COUGH- PERSISTENT OR BLOODY
- YES NO-----DIABETES
- YES NO-----DIGESTIVE DISORDERS
- YES NO-----DEGENERATIVE JOINT DISEASE
- YES NO-----EMPHYSEMA
- YES NO-----EPILEPSY
- YES NO-----FAINTING OR DIZZY SPELLS
- YES NO-----GLAUCOMA
- YES NO-----HEADACHES _____
- YES NO-----HEART MURMUR _____
- YES NO-----HEPATITIS--TYPE _____
- YES NO-----HERPES VIRUS _____
- YES NO-----HIGH BLOOD PRESSURE
- YES NO-----KIDNEY DISEASE
- YES NO-----LIVER DISEASE &/OR JAUNDICE
- YES NO-----LOW BLOOD PRESSURE
- YES NO-----MITRAL VALVE PROLAPSE
- YES NO-----NURSING/BREAST-FEEDING A CHILD
- YES NO-----ORGAN TRANSPLANT RECIPIENT
- YES NO-----PREGNANT CURRENTLY--DUE DATE: _____
- YES NO-----PACEMAKER
- YES NO-----PSYCHIATRIC DISORDER
- YES NO-----RADIATION TREATMENT
- YES NO-----RHEUMATOID ARTHRITIS
- YES NO-----RHEUMATIC FEVER
- YES NO-----RESPIRATORY DISEASE
- YES NO-----SCARLET FEVER
- YES NO-----SHORTNESS OF BREATH
- YES NO-----SINUS PROBLEMS
- YES NO-----SKIN PROBLEMS/ RASHES
- YES NO-----STENT PLACEMENT _____
- YES NO-----STROKE
- YES NO-----SWOLLEN FEET OR ANKLES
- YES NO-----THYROID PROBLEMS
- YES NO-----TUBERCULOSIS
- YES NO-----TUMORS/ GROWTHS _____
- YES NO-----ULCERS
- YES NO-----UNEXPLAINED WEIGHT LOSS
- YES NO-----VENEREAL DISEASE
- YES NO-----I HAVE BEEN TOLD TO PREMEDICATE WITH AN ANTIBIOTIC PRIOR TO DENTAL TREATMENTS.

DO YOU HAVE ANY OTHER DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?
