

MEDICAL HISTORY

DATE OF BIRTH _____

PATIENT'S NAME _____

MEDICAL DOCTOR _____

ACCOUNT # _____

DATE OF LAST PHYSICAL EXAM _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

List all <u>medications</u> , <u>herbal remedies</u> , and <u>nicotine replacement therapy</u> you are taking, including <u>over-the-counter</u> :	List all substances you are allergic to:

Do you now have, OR have you ever had, any of the following? Circle 'Y' for yes or 'N' for no

AIDS	Y / N	Epilepsy / Seizures	Y / N	Joint replacement	Y / N
Anemia	Y / N	Fen-Fen Redux	Y / N	Kidney disease	Y / N
Anxiety Disorder	Y / N	Gastro-esophageal reflux disease	Y / N	Liver disease	Y / N
Arthritis	Y / N	Glaucoma	Y / N	Psychiatric treatment	Y / N
Artificial heart valves	Y / N	Heart murmur	Y / N	Pacemaker	Y / N
Asthma	Y / N	Heart surgery	Y / N	Sensitivity to metals or latex	Y / N
Bisphosphonates (Fosamax)	Y / N	Heart trouble	Y / N	Sexually transmitted diseases	Y / N
Osteoporosis treatment	Y / N	Hepatitis type	Y / N	Sinus trouble	Y / N
Cancer or tumor	Y / N	High blood pressure	Y / N	Stroke	Y / N
Diabetes	Y / N	HIV positive	Y / N	Tuberculosis	Y / N

- Have you been treated by a physician or hospitalized in the past year? Yes No
If Yes, explain: _____
- Has there been any change in your general health in the past year? Yes No
If Yes, what? _____
- Are you experiencing any unresolved stress? Yes No
- Have you had any unusual reaction to "novocaine" or local anesthetic? Yes No
- Have you ever had problems with prolonged bleeding from a cut, injury, or tooth extraction? Yes No
- Are you in a substance abuse recovery program? Yes No
- Have you ever used, or are you currently using any narcotic **or** recreational drugs? Yes No
- Are you pregnant or possibly pregnant? **If Yes, when due?** _____ Yes No
- Are you taking birth control pills or other hormones? Yes No
- Is there anything related to your medical history that you have not indicated above? Yes No
If Yes, explain: _____
- Have you ever used, or are you currently using, Tobacco? Yes No
 How often per day? _____ Start or Quit Date? _____ Would you like to stop? Yes No
- What is the usual amount of alcohol you consume per day _____, per week _____, per month _____

PATIENT / Guardian Signature _____ **Date** _____

****Patient: Please complete the back side of this form.****

Provider Signature / Date / Comments	
Provider Signature / Date / Comments	Provider Signature / Date / Comments
Provider Signature / Date / Comments	Provider Signature / Date / Comments

ASA	Antibiotic Pre-med	Allergies	Hepatitis	Heart Condition	Medication	Anesthetic	Other (specify)	Other (specify)
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PLEASE ANSWER THE FOLLOWING QUESTIONS:

- 1. Please list your dental complaints or concerns, if any, _____

- 2. What do you want to accomplish in terms of your oral health? _____
- 3. Are you having any pain or discomfort at this time?.....Yes No
- 4. Is there anything about the appearance of your teeth/smile you would like to change?

- 5. How do you presently take care of you teeth and gums?.....Flossing Yes No
Toothbrush: Hard Soft PowerHow often per day? _____
- 6. Do you have sensitive teeth? If so, when: _____
- 7. When was your last visit to the dentist? _____
- 8. What services were provided? _____
- 9. Who was your former dentist? _____ City/State: _____
- 10. How did you hear about us? _____
- 11. Would you like to learn how to prevent tooth decay and control gum disease?Yes No

GENERAL RISK-SELF ASSESSMENT:

- 12. Does your mouth seem dry?.....Yes No
- 13. During the day, do you eat and snack on sugary foods, drinks, gum or mints?Yes No
- 14. Are you nervous about having dental treatment ?.....Yes No
- 15. Have any of your family members had gum disease?.....Yes No
- 16. Have any of your family members had excessive cavities?Yes No

PERIODONTAL RISK-SELF ASSESSMENT:

- 17. Have you had, or ever been told that you have “gum disease”, “deep pockets” or periodontal disease?
.....Yes No
- 18. Currently, do you have sore or bleeding gums?Yes No

CARIES RISK-SELF ASSESSMENT:

- 19. Do you seem to have new cavities at each dental check-up?Yes No
- 20. Do you use xylitol or fluoride toothpaste?Yes No
- 21. Do you use xylitol or fluoride rinses?Yes No
- 22. Do your live in an area with fluoridated water?Yes No
- 23. Have you had a lot of “fillings”?Yes No
- 24. How long ago did you have you last filling? _____

*****PATIENT: PLEASE DO NOT WRITE BELOW THIS LINE *****

PROVIDER COMMENTS:	
DR OR RDH Signature	Date