DENTAL AND MEDICAL HISTORY FORM

File No:_____

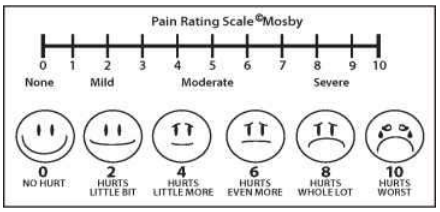
NAME: _____ DOB:_____ PAYMENT METHOD: _____

If under 18 Name Of Guardian/Parent:_____ Phone/Contact: _____ _____ _____

Email: _____

1) THE MAIN REASON FOR MY DENTAL APPOINTMENT IS: _____

2) ARE YOU IN DENTAL PAIN? YES NO



IF YES, ON THE PAIN SCHEDULE PLEASE CIRCLE HOW MUCH PAIN YOU ARE IN:

WHERE IS THE PAIN?

UPPER RIGHT	**UPPER FRONT**	**UPPER LEFT**
LOWER RIGHT	**LOWER FRONT**	**LOWER LEFT**

DESCRIBE THE PAIN: THROBBING, SHARP, CONSISTENT, INTERMITTENT, DULL

3) DATE OF LAST DENTAL EXAMINATION (MM/YY) _____

4) HOW SATISFIED HAVE YOU BEEN WITH YOUR PREVIOUS DENTAL CARE?

1 2 3 4 5

NOT SATISFIED ***VERY SATISFIED***

5) DO YOU FEAR RECEIVING DENTAL CARE? YES NO UNSURE

THE FOLLOWING INFORMATION IS ESSENTIAL FOR THE SAFE AND EFFECTIVE DIAGNOSIS AND TREATMENT OF EACH PATIENT. **DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

6) CONGENITAL HEART DISEASE/ HEART MURMUR/RHEUMATIC FEVER ..... Y N
7) HEART ATTACK ..... Y N
8) IRREGULAR HEART BEAT ..... Y N
9) ANGINA/CHEST PAIN ..... Y N
10) HEART SURGERY ..... Y N
11) ARTIFICIAL HEART VALVE ..... Y N
12) HEART PACE MAKER ..... Y N
13) HIGH BLOOD PRESSURE ..... Y N
14) LOW BLOOD PRESSURE ..... Y N
15) STROKE/PARALYSIS ..... Y N

RESPIRATORY

16) ASTHMA ..... Y N
17) BREATHING PROBLEM (SLEEP APNEA, EMPHYSEMA, SHORTNESS OF BREATH, OXYGEN DEPENDENT, COUGH) ..... Y N
18) TUBERCULOSIS ..... Y N

GASTRO-INTESTINAL

19) KIDNEY DISEASE ..... Y N
20) LIVER DISEASE/YELLOW JAUNDICE ..... Y N
21) STOMACH/INTESTINAL DISEASE/ULCERS . . Y N REFLUX

NEUROLOGY

22) CONVULSIONS/SEIZURES/EPILEPSY ..... Y N
23) NUMBNESS OR TINGLING/BACKPAIN ..... Y N
24) PSYCHIATRIC TREATMENT ..... Y N
25) FAINTING/DIZZINESS ..... Y N

ENDOCRINE

26) DIABETES TYPE 1 TYPE 2 ..... Y N
27) STEROID TREATMENT (CORTISONE) ..... Y N

HEMATOLOGY

28) BLEEDING/BRUISING EASILY/ BLOOD DISORDER ..... Y N
29) IMMUNE SYSTEM (LUPUS, IMMUNODEFICIENCY, SJOGRENS) ..... Y N
30) 30) BLOOD THINNER: (WAREFIN, HEPARIN APIXABAN, RIVAROXABAN, EDOXABAN, DABIGATRAN) ..... Y N

INFECTIOUS DISEASE

31) HIV/AIDS ..... Y N
32) HERPES ..... Y N
33) HEPATITIS A, B or C ..... Y N

MUSCULOSKELETAL

34) RHEUMATISM/ARTHRITIS/PAIN IN JOINTS . Y N
35) ARTIFICIAL JOINT ..... Y N
36) OSTEOPOROSIS/BISPHOSPHONATE THERAPY **. . Y N**
(Boniva, Fosamax, Zometa, etc.)

GENERAL

37) CURRENT CANCER ..... Y N
38) PAST CANCER ..... Y N
39) RADIATION THERAPY ..... Y N
40) CHEMOTHERAPY ..... Y N
41) RECENT WEIGHT GAIN/LOSS ..... Y N
42) DRUG/ALCOHOL TREATMENT ..... Y N
43) HIVES/RASH ..... Y N
44) DIFFICULTY HEARING ..... Y N
45) EYE PROBLEMS (DRY EYES/GLAUCOMA) . . Y N

WOMEN ONLY:

46) ARE YOU OR COULD YOU BE PREGNANT?: . Y N

47) ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE?

48) HAVE YOU BEEN HOSPITALIZED IN THE PAST YEAR? IF YES - WHAT WERE YOU TREATED FOR?

49) HAVE YOU EXPERIENCED AN UNUSUAL OR ALLERGIC REACTION TO ANY OF THE FOLLOWING?

_____ **LOCAL ANESTHETIC**	_____ **CODEINE**
_____ **PENICILLIN**	_____ **NARCOTICS**
_____ **SULFA DRUGS**	_____ **LATEX RUBBER**
_____ **ASPIRIN**	_____ **METALS**

_____ **OTHERS** _____

50) PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING:
(INCLUDING OVER THE COUNTER, OR SUPPLEMENTS OR HERBALS)

NAME	DOSAGE	ROUTE OF INTAKE	MEDICAL CONDITION

51) TOBACCO USE
CIGARETTES
_____ **QUIT: DATE** _____
_____ **NEVER**
_____ **CURRENT SMOKER: PACKS/DAY** _____ **NUMBER OF YRS** _____

OTHER TOBACCO: PIPE_____ **CIGAR** _____ **MAVO**_____ **CHEW**_____**BETEL QUID** ____

ARE YOU INTERESTED IN QUITTING? NO _____**YES** _____

52) ALCOHOL USE
DO YOU DRINK ALCOHOL? _____ **YES** _____ **NO NUMBER DRINKS/WEEK** _____

53) DRUG USE

DO YOU USE ANY RECREATIONAL DRUGS?	**YES**	**NO**
HAVE YOU EVER USED NEEDLES?	**YES**	**NO**

54) WEIGHT _____ **HEIGHT** _____

I CERTIFY THAT ALL THE INFORMATION I HAVE PROVIDED IS TRUE TO MY KNOWLEDGE.

PATIENT'S SIGNATURE: _____ **DATE.**_____