MEDICAL HISTORY

PLEASE INDICATE IF YOU HAVE A HISTORY OF THE FOLLOWING:

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Birth Defects
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Blood Transfusion(s)
- ☐ Bowel Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Fosamax, Redux, Pondimin
- ☐ Glaucoma/Eye Disease
- ☐ Growth/Development Disorder
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Pain/Angina
- ☐ Hepatitis: ☐ A ☐ B ☐ C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hip Replacement ☐ R _____ ☐ L _____
- ☐ HIV
- ☐ Hives
- ☐ Hormone Replacement
- ☐ Kidney Disease
- ☐ Knee Replacement ☐ R _____ ☐ L _____
- ☐ Liver Cancer
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lung/Respiratory Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pre-Medicate for _____
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Reflux/GERD
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Tuberculosis
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Visual Impairment
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

☐ NO KNOWN CONDITIONS

LIST OTHER PAST MEDICAL PROBLEMS:

LIST MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____

☐ SEE ATTACHED LIST

☐ I do not currently take any medications.

LIST ALLERGIES:

- ☐ Amoxicillin _____
- ☐ Aspirin _____
- ☐ Codeine _____
- ☐ Latex _____
- ☐ NSAIDs _____
- ☐ Penicillin _____
- ☐ Seasonal Allergy _____
- ☐ Sulfa Drugs _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

☐ NO KNOWN ALLERGIES

MD CLEARANCE INFORMATION:

Name of MD: _____

Phone: _____

FAX: _____

FOR WOMEN ONLY:

Are you or could you be pregnant? ☐ YES ☐ NO

Are you on birth control pills? ☐ YES ☐ NO

PERIODONTAL HISTORY:

A. WHAT IS YOUR UNDERSTANDING OF WHY YOU ARE HERE TODAY?

B. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING IN THE LAST 3 YEARS?

Bleeding gums from brushing or flossing? ☐ YES ☐ NO

Sensitive gums or teeth? ☐ YES ☐ NO

Bad breath or foul taste in mouth? ☐ YES ☐ NO

Abscesses or swelling? ☐ YES ☐ NO

Grinding or clenching of your teeth? ☐ YES ☐ NO

Food impaction between your teeth? ☐ YES ☐ NO

C. HAVE YOU EVER HAD OR EXPERIENCED:

Periodontal consultation or treatment? ☐ YES ☐ NO

Root canal treatment? ☐ YES ☐ NO

Complications following dental treatment? ☐ YES ☐ NO

Reactions to dental anesthetic or drugs? ☐ YES ☐ NO

Fainted in a dental office? ☐ YES ☐ NO

FOR OFFICE USE ONLY

CC:

Stress: ☐ Mild ☐ Moderate ☐ High

Smokes: ☐ Yes ☐ No

Natural Teeth v. Full Denture

Thoughts/Questions/Concerns:

Last Dental Cleaning:

Freq:

Present Home Care

Brushing ____ x/day

Flossing ____ x/

Proxabrush ____ x/

Mouthrinse ____ x/

Other ____ x/