DENTAL and MEDICAL HISTORY

What would you like us to do today?_____

Are you in dental discomfort today?_____

Former Dentist _____
Address_____

Dentist's Email _____

Phone _____

Date of last dental care _____

Date of last x-rays _____

Check (_) yes or no if you have had problems with any of the following:

__Y __N Bad breath
__Y __N Bleeding gums
__Y __N Popping jaw*
__Y __N Sore jaw muscles*
__Y __N Grinding Teeth*
__Y __N Clenching teeth*
__Y __N Loose teeth
__Y __N Broken fillings
__Y __N Gum/Perio Surgery
__Y __N Sensitivity to cold
__Y __N Sensitivity to hot
__Y __N Sensitivity to sweets
__Y __N Sensitivity to biting*
__Y __N Sores in mouth
__Y __N Frequent Snoring*
__Y __N Frequent feelings of exhaustion or sleepiness*

(If you answered Yes to *more than one* of the above questions with a * next to it, please fill out the attached separate form called "Sleep Screening Questionnaire." If not, filling out that form is optional.)

How often do you brush? _____
Floss? _____
How do you feel about the appearance of your teeth? _____
_____

Are there any specific dental procedure that you would like to learn more about (ie Implants, Gum Grafting, Tooth Whitening, etc…)? _____
_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?
_____
_____

Physician's name _____

Phone_____ Date of last visit _____

Have you had any serious illnesses or operations? Y ___ N ___ If yes, describe

_____

Are you currently under physician care? Y ___ N ___ If yes, please describe:

_____

Are you, or have you ever, used a bisphosphonate medication? (Bisphophonates are a medication that strengthen the bones, and are usually prescribed as a way to slow down certain bone cancers, or some types of arthritis. Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva) __ Y __ N

If yes, when did you stop taking it, or are you currently taking it?

_____

Women: Are you pregnant? __ Y __ N Nursing? __ Y __ N Taking birth control pills? __ Y __ N

Check (_) yes or no whether you have had any of the following:

__Y __N HIV Positive
__Y __N Anaphylaxis
__Y __N Anemia
__Y __N Arthritis
__Y __N Artificial heart valves
__Y __N Artificial joints
__Y __N Asthma
__Y __N Back problems
__Y __N Blood disease
__Y __N Cancer
__Y __N Chemical dependency
__Y __N Chemotherapy
__Y __N Circulatory problems
__Y __N Cough up blood
__Y __N Diabetes
__Y __N Epilepsy
__Y __N Eye Surgeries
__Y __N Fainting
__Y __N Glaucoma
__Y __N Heart murmur
__Y __N Heart problems or Surgery. Describe: _____ _____
__Y __N Hemophilia
__Y __N Hepatitis
__Y __N High blood pressure
__Y __N Jaw pain
__Y __N Kidney disease or malfunction
__Y __N Liver disease
__Y __N Material allergies (latex, wool, metal, chemicals) Describe _____
__Y __N Mitral valve prolapse
__Y __N Nervous problems
__Y __N Pacemaker
__Y __N Psychiatric care
__Y __N Radiation treatment
__Y __N Respiratory disease
__Y __N Rheumatic/Scarlet fever
__Y __N Shortness of Breath
__Y __N Sleep Apnea
__Y __N Stroke
__Y __N Surgical implant
__Y __N Swelling of feet or ankles
__Y __N Thyroid disease or malfunction
__Y __N Tobacco habit
__Y __N Tuberculosis

What medications are you currently taking?

_____

_____

What (if any) substances are you taking recreationally? _____

Do you have any allergies? _____

Do you have any drug allergies? _____