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Medical History (New Patient Form)

Patient's Name: _____

Primary Care Doctor: _____

When was the last time you saw a doctor? _____

If so, why? _____

Have you been hospitalized in the last two years? No _____ Yes _____

If so, why? _____

Please list all medications/drugs/vitamins/herbs that you are taking:

_____

_____

Have you ever had an adverse reaction or allergies to any medication or substance?

_____ Aspirin
_____ Codeine
_____ Dental Anesthetics
_____ Erythromycin
_____ Iodine
_____ Latex
_____ Nitrous Oxide
_____ Metals
_____ Penicillin
_____ Peanuts/Milk/Food Allergies
_____ Sulfa Drugs
_____ Tetracycline
_____ Valium or other Sedatives
_____ Others _____

Please check all that apply to your medical history:_____

Heart/Circulation/Autoimmune Disorders:

Did you know that gum disease can increase your risk of heart attack and stroke?

_____ Bleeding Problem/Anemia
_____ Congenital Heart Defect
_____ Heart/Valve Surgery
_____ Heart Attack/ Stroke/TIA
_____ Heart Murmur
_____ High Blood Pressure (____/____)
_____ HIV/AIDS
_____Lupus/Scleroderma

Do you pre-medicate with antibiotics for dental procedures? No _____ Yes _____
Have you ever been told you needed to pre-medicate? No _____ Yes _____

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Lungs/Breathing:

Did you know that a dry mouth can put you at a much higher risk for dental cavities and gum disease?

_____ Asthma
(Do you carry a rescue inhaler? No _____Yes _____)
_____ COPD/Emphysema
_____ Dry Mouth
_____ Lung Disease
_____ Sleep Apnea
(Do you use a CPAP? No _____ Yes _____)
_____ Snoring
_____ Tuberculosis

Joints/Bones:

Did you know that there is a link between dental bacteria and joint infections?

_____ Arthritis
(Type of Arthritis _____)
_____ Artificial Joint
(Do you pre-medicate for dental procedures? No ____ Yes _____)
_____ Osteoporosis
(Do you take medication to correct? No ____ Yes _____)

Metabolic Disease/ GI:

Did you know that Diabetes and gum disease are detrimentally linked?

_____ Acid Reflux/Ulcers
_____ Diabetes Type I
_____ Diabetes Type II
_____ Frequent Thirst
_____ Frequent Urination
_____ Frequent Hunger
_____ Hypoglycemia
_____ Hepatitis A
_____ Hepatitis B
_____ Hepatitis C
_____ Kidney Disease
_____ Liver Disease
_____ Thyroid Disease
_____Transplant _____

Diabetics: Do you know your most recent A1C number? _____%
Normal range: 5.5-6.0% and below

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Head and Neck/Neurologic:

Did you know that jaw /TMJ problems can cause headaches, ear pain, bite problems and can lead to tooth wear and oral bone loss?

_____ Dizziness or Fainting
_____ Ear Problems/ Ringing
_____ Fever Blisters/ Cold Sores
_____ Jaw Joint Pain/ TMD
_____ Migraines/ Headaches
_____ Seizures
_____ Sinus Problems

Behavioral:

Did you know that drinking alcohol and using tobacco together increases your risk of oral cancer exponentially?

_____ Alcohol Abuse
_____ Depression
_____ Drug Addiction
_____ Eating Disorders
_____ Bipolar Disease/ Schizophrenia
_____ Tobacco
(What kind of tobacco, how often, how long? _____)

History of Cancer:

Did you know that oral cancer is on the rise in non-smokers and non-drinkers due to the human papilloma virus? (HPV) 1 out of 100 people will get oral/throat cancer.

If yes, what kind of cancer? _____
When were you diagnosed? _____
How was/is it being treated? _____

Women Only:

Did you know that pregnant women with gum disease may be 4-8x more likely to give birth to pre-term, low birth weight babies?

Are you currently pregnant? No _____ Yes _____

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Dental History

What are your current dental concerns? _____
_____

How long has it been since your last dental visit? _____
What was done? _____

Are you happy with the appearance of your teeth?
Yes _____No _____
Would you like them to be straighter?
Yes _____No _____
Would you like them to be whiter?
Yes _____No _____

How often do you brush? _____
How often do you floss? _____
How often do you use other aids? _____

Have you ever avoided regular dental care?
Yes _____No _____
Why? _____

Do you feel like you might clench or grind when you sleep or experience stress?
Yes _____ No _____

Have you been told in the past that you need a nightguard or occlusal guard?
Yes _____ No _____

Have you been told in the past that you have gum disease or periodontal disease?
Yes _____ No _____

Have you had previous gum treatments, scaling and root planing or more frequent professional cleanings?
Yes _____ No _____

What are your dental expectations?
_____
_____

Shall we request records from your previous dentist?
Yes _____ No _____

Name of last dentist? _____
City, State? _____