Medical/Dental History

Name _____ DOB____/____/_____

All information given is strictly confidential and will not be released to anyone without approval. It is for your safety that the dental hygienist knows your entire medical/dental history to provide safe and complete treatment.

Primary Reason for visit: Routine Cleaning Whitening Periodontal Exam

Family Physician Name_____ Phone # _____

Are you allergic to any medications, foods, or products such as latex? _____

_____Codeine _____Penicillin _____Aspirin _____Acrylic _____Latex _____Sulfa

Have you ever taken any Bis-phosphonate medications (ie: Zometa, Aredia, Boniva, Actonel, Fosamax, Skelid, Didronel?) Yes No

List all medications you are currently taking. Please include all prescription, inhaler, homeopathic, and herbal medications: _____

_____

__Artificial Joint __Metal Plates & Screws When_____ Where_____ __Osteoporosis __Arthritis __Jaw Joint Problems/ TMJ __Kidney disease/transplant __Liver disease/transplant __Skin disease/cancer __Cancers Where_____ When_____ __Chemical dependency __Drug __Alcohol __Tobacco use __Smoke____pk/day for____yrs __Dip____cans/day for_____yrs	__High blood pressure __Clotting problems __Anemia __Hemophilia/easy bruising __Feet/ankles swelling __Diabetes, type _____ __Thyroid problems __Stroke __Seizure/Epilepsy __dementia __Anxiety __Depression/bipolar __Schizophrenia __Sleep apnea/snoring __Sinus problems __Hay Fever/allergies __Glaucoma	__Heart Attack __Heart Murmur __Heart Failure __Heart surgery/bypass __Pacemaker __Angina (chest pain) __Rheumatic fever __Artificial heart valve/stents __Asthma __Pneumonia/Bronchitis __Emphysema __Shortness of breath __Tuberculosis __Hepatitis A/B __HIV/AIDS

List all serious illnesses, hospitalizations, and surgeries in the last 5 years:_____

_____

_____

Dental History

__Do your gums bleed while brushing or flossing? __Are your teeth sensitive to hot or cold? __Are your teeth sensitive to sour or sweet? __Do you have sores or lumps in your ears or mouth? __Do you have any head, neck, or jaw injuries? __Do you experience any clicking or popping in jaw? __Do you experience any problems with opening or closing? __Do you have frequent headaches? __morning __evening __Do you clench or grind your teeth? __Do you have an unpleasant odor or taste in your mouth? __Have you had difficulty with extractions in the past? __Have you ever had instruction on the proper way to brush? __Have you ever had instruction on correct gum care?	__Unhappy with the appearance of your teeth? __Unfavorable dental experience/ dental fears? __Problems with anesthetic/ hard to numb? __Previous orthodontic treatment? When_____ __Previous periodontal treatment? When_____ __How many times do you brush per day?_____ __How often do you floss?_____ __Do you use a manual or electric toothbrush? _____ __Do you use any type of mouth rinse?_____ _____ __Is there anything you would change about your smile?_____

The responses on this questionnaire are accurate to the best of my knowledge. If there is any change in my medical status I will inform my Hygienist.

Patient Signature or Parent/Guardian of Child _____ **Date**_____

Dental Hygienist Signature _____**Date**_____