MEDICAL AND DENTAL HISTORY

DETAIL DENTAL

1

NAME: ______________________ DATE: ______________

GENERAL INFORMATION

1. a. **Date of Birth:** ______ Month ____ Day ______ Year
b. **Gender:** ○ **Male** ○ **Female**
c. **Weight:** ________ lbs.
d. **Height:** ______ ft. ______ inches
e. Neck Size: inches

GENERAL MEDICAL INFORMATION

2. Please rate your health. ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
3. Have you ever taken Bisphosphonates for Osteoporosis, such as Fosamax, Actonel, or Aclasta? Yes No
4. Your Physician: ______________________ City______________ Phone No.: ______________
5. Date of last physical examination: Month _______ Year ________ Currently under treatment by a physician? ○ Yes ○ No

   Please explain____

6. Do you engage in regular exercise? ○ Yes ○ No Type_______________________________
7. **Do you need to take antibiotics prior to receiving dental or surgical care?** ○ **Yes** ○ **No** ○ **Don't know**

MAJOR HOSPITALIZATIONS, SURGERIES, AND BLOOD TRANSFUSION → ○ MARK HERE IF NONE ○

8. DATE (Month/Year)	REASON

ALLERGIC OR UNUSUAL REACTION TO ANY OF THE FOLLOWING? → ○ MARK HERE IF NONE ○

9. ○ Penicillins ○ Sulfa drugs ○ Aspirin ○ Local anesthesia
○ Opiates/codeine ○ Iodine ○ Latex
○ Other drugs: List: 1. ____________ 2. ____________ 3. ____________
○ Other substances (food, metals, etc.) List: 1. ____________ 2. ____________ 3. ____________

Type of Reaction ____

WOMEN ONLY → ○ NOT APPLICABLE

10. **Are you** ○ **PREGNANT?** ______ weeks? ○ Trying to become pregnant? ○ Not sure if you are pregnant?
○ Using birth control pills ____________________ (Name of Prescription) ○ Going through menopause? ○ Post-menopausal?

PRESCRIPTION/ NON PRESCRIPTION MEDICATIONS → ○ MARK HERE IF NONE
(Use continuation page if necessary)

11. List all medications and herbal supplements/remedies that you are currently taking.

	Name:	For what Condition?	Dose/Frequency of use:
A)			
B)			
C)			
D)			
E)			
F)			

Detail Dental

GENERAL MEDICAL INFORMATION - PRESENT SYMPTOMS

12. Mark symptom(s) that you NOW experience or HAVE RECENTLY experienced. → ○ **CHECK HERE IF NONE**

GENERAL
- ○ Weight loss________ Lbs. Over what time period? __________
- ○ Weight gain________ Lbs. Over what time period? __________
- ○ Loss of appetite ______________________
- ○ Always hungry ______________________
- ○ Always thirsty ______________________
- ○ Frequent urination______________________
- ○ Fatigue ______________________
- ○ Faint easily ______________________
- ○ Night sweats______________________
- ○ Bleed easily ______________________
- ○ Bruise easily______________________

CARDIOVASCULAR
- ○ Shortness of breath with exertion______________________
- ○ Racing or irregular heart beat______________________
- ○ Swollen ankles ______________________
- ○ Cold ankles/feet ______________________
- ○ Chest pain/angina______________________

RESPIRATORY
- ○ Coughing spell______________________
- ○ Wheezing______________________
- ○ Use 2 or more pillows to sleep______________________

MUSCULOSKELETAL
- ○ Joint pain ______________________
- ○ Swollen joints ______________________
- ○ Muscle cramping______________________

SKIN CHANGES
- ○ Skin problems______________________
- ○ Nail changes______________________

NEUROLOGICAL
- ○ Numbness/tingling______________________
- ○ Paralysis/weakness______________________
- ○ Memory changes______________________
- ○ Smell/taste changes______________________
- ○ Difficulty chewing______________________
- ○ Swallowing changes______________________
- ○ Speech changes______________________
- ○ Dizzy spells or fainting______________________

GASTROINTESTINAL
- ○ Indigestion ______________________
- ○ Reflux/heartburn______________________
- ○ Nausea/vomiting______________________
- ○ Bowel problems______________________

HEAD & NECK
- ○ Neck pain______________________
- ○ Neck lump/swelling______________________
- ○ Headache______________________
- ○ Facial pain ______________________
- ○ Jaw pain______________________

SALIVARY
- ○ Need liquid to swallow dry foods______________________
- ○ Mouth feels dry when eating a meal______________________
- ○ Difficulties swallowing any foods______________________
- ○ Sense of too little saliva______________________
- ○ Sense of too much saliva______________________

EYES
- ○ Vision changes______________________
- ○ Dry eyes______________________

EARS
- ○ Hearing loss______________________
- ○ Ringing ears______________________
- ○ Earaches ______________________
- ○ Pressure/stuffiness in ears______________________

NOSE/THROAT
- ○ Congested/runny nose______________________
- ○ Nose bleeds ______________________
- ○ Nasal obstruction ______________________
- ○ Sore throat ______________________
- ○ Hoarseness/voice changes ______________________
- ○ Mouth breathing/ snoring ______________________

PAIN
- ○ Back pain______________________
- ○ Other pains ______________________

BEHAVIORAL
- ○ Stress______________________
- ○ Sleep difficulties______________________
- ○ Feel depressed ______________________
- ○ Feel agitated/anxious______________________
- ○ Other ______________________

FAMILY MEDICAL HISTORY

○ **MARK HERE IF NO ONE IN YOUR FAMILY HAS *EVER* HAD ANY OF THE PROBLEMS LISTED BELOW**

13. **Darken the circle beside medical problems that have been present in your parents, brothers/sisters, or close relatives**.

- ○ Genetic (inherited) disease ______________________
- ○ Liver/kidney disease______________________
- ○ Immune system disease ______________________
- ○ Diabetes______________________
- ○ Bleeding disorders ______________________
- ○ Tuberculosis______________________
- ○ Neurologic disease______________________
- ○ Other (include cancer)______________________

Detail Dental

MEDICAL HISTORY - PAST AND PRESENT ILLNESS

14. **Check the box for illnesses that you CURRENTLY HAVE or HAVE HAD IN THE PAST**

○ **CHECK HERE IF NONE**

Cancer & Neoplastic Disease
- ○ Cancer ____
- ○ Leukemia/Lymphoma ____

Genetic (inherited) Disease
- ○ Type ____

Immune System Disorder
- ○ Rheumatoid arthritis ____
- ○ Lupus erythematosus ____
- ○ Sjogren's Syndrome ____
- ○ Other ____

Hormonal or Metabolic Disorders
- ○ Diabetes ____
- ○ Thyroid problems ____
- ○ Adrenal insufficiency ____
- ○ Other ____

Heart/Blood Disorders
- ○ High blood pressure ____
- ○ Artherosclerosis ____
- ○ Heart attack ____
- ○ Coronary artery disease ____
- ○ Heart murmur ____
- ○ Heart valve problems ____
- ○ Bleeding disorder ____
- ○ Anemia ____
- ○ Other ____

Neurological Disorders
- ○ Epilepsy/Seizures ____
- ○ Neuralgia ____
- ○ Stroke ____
- ○ Other ____

Chronic Pain
- ○ Back ____
- ○ Abdominal ____
- ○ Headache/Migraine ____
- ○ Other ____

Head and Neck Conditions
- ○ Injury to face, jaws, neck ____
- ○ Concussion ____
- ○ Radiation treatment ____
- ○ Temporomandibular joint disease ____
- ○ Salivary gland problems ____
- ○ Sinusitis ____
- ○ Glaucoma ____
- ○ Other ____

Gastrointestinal Disorders
- ○ Acid-reflux /Heartburn ____
- ○ Ulcer/Gastritis ____
- ○ Irritable bowel syndrome/Colitis ____
- ○ Other ____

Lung/Airway Disorders
- ○ Emphysema ____
- ○ Pneumonia ____
- ○ Bronchitis ____
- ○ Asthma ____
- ○ Tuberculosis ____
- ○ Sleep Apnea ____
- ○ Other ____

Skin Disorders
- ○ Skin cancer ____
- ○ Skin infections ____
- ○ Other ____

Other Major Organ Disease
- ○ Kidney disease ____
- ○ Liver disease ____
- ○ Organ transplant ____
- ○ Spleen surgery ____
- ○ Other ____

Infectious Diseases
- ○ Rheumatic fever ____
- ○ Strep Throat ____
- ○ Mononucleosis ____
- ○ Hepatitis ____
- ○ Sexually-transmitted diseases ____
- ○ HIV/AIDS ____
- ○ Other ____

Behavioral Conditions
- ○ Psychiatric illness ____
- ○ Anxiety/Panic attacks ____
- ○ Depression ____
- ○ Suicide attempt or thoughts ____
- ○ Other ____

Habits/Addiction
- ○ Drug abuse ____
- ○ Alcohol abuse ____

Other Conditions
- ○ Disabled ____
- ○ Prosthetic valve ____
- ○ Prosthetic joint ____

Comments Regarding Conditions Checked Above

(Please write comments about positive responses in this space as needed

15. CONSUMPTION OF BEVERAGES AND OTHER SUBSTANCES → ○ **MARK HERE IF NONE**

a. Number of caffeinated beverages you drink in a day:
○ 0 ○ 1-2 ○ 3-5 ○ 5+

b. Number of alcoholic beverages you drink in a week:
○ 0 ○ 1-2 ○ 3-5 ○ 6-10 ○ 10+

d. Number of carbonated beverages a day:
○ 0 ○ 1-2 ○ 3-5 ○ 5+

c. Currently using any street or recreational drugs?
○ No ○ Yes (Type?)________________________

e. Have you ever used tobacco? ○ No ○ Yes
If yes, what type:
○ Cigarette ○ Pipe/Cigar ○ Smokeless

f. Do you currently use tobacco? ○ No ○ Yes
If yes, average number of uses per day: ________
For how many years? _____

16. **DENTAL HISTORY : Darken the circle beside items that describe your past dental problems and dental care.**

○ Regular dental care
○ Occasional dental care
○ Wisdom tooth extractions
○ Orthodontics
○ Gum disease (pyorrhea, gingivitis or periodontal disease)
○ Treatment for jaw trauma/fracture (Type?)________________________
○ Had an adverse reaction to dental treatment (Please describe)________________________
○ Dental fears or anxiety________________________

17. Rate your ORAL HEALTH in general. ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

18. How good a job do you feel you are doing in taking care of your oral health?
○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

19. Date of last regular dental visit: ____ _____ Name and address of dentist: ________________________
Month Year
____
____

FAMILY DENTAL HISTORY

20. Darken the circle beside oral problems that have been present in your parents, brothers/sisters, or close relatives.
○ Caries ○ Gum disease (pyorrhea, gingivitis or periodontal disease) ○ Dry Mouth ○ TMJ disorder

DOCTOR'S USE

Additional Notes or Comments:

Patient's Signature____**Date**____________

Reviewed by: ____
Date____________

Detail Dental