DETAIL DENTAL

MEDICAL & DENTAL HISTORY

NAME: _____ DATE: _____ *mm/dd/yy*

GENERAL INFORMATION

1. a. Date of Birth: _____ *mm/dd/yy*

b. Gender: ☐ Male ☐ Female

c. Weight: _____ lbs.

d. Height: _____ ft. _____ in.

e. Neck Size: _____ in.

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. Has anyone told you you Snore ? ☐ Yes ☐ No How often? _____

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 ☐ Opiates/codeine
☐ Sulfa drugs ☐ Iodine
☐ Aspirin ☐ Latex
☐ Local anesthesia

Other drugs:
1. _____
2. _____
3. _____

Other substances (food, metals, etc.)
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.

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

GENERAL MEDICAL INFORMATION - PRESENT SYMPTOMS

12. Mark symptom(s) that you NOW experience or HAVE RECENTLY experienced. → ☐ MARK HERE IF NONE

GENERAL
- ☐ Weight loss _____ Lbs. Over time period? _____
- ☐ Weight gain _____ Lbs. Over 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. Indicate any 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) _____

MEDICAL HISTORY - PAST AND PRESENT ILLNESS

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

MEDICAL HISTORY

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 : Indicate items that describe your past dental problems and dental care.

☐ Regular dental care
☐ Wisdom tooth extractions
☐ 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
☐ Occasional dental care
☐ Orthodontics

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 & address of dentist: _____
Month Year

FAMILY DENTAL HISTORY

20. Indicate below any 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 _____