DR. T DENTAL
FAMILY AND COSMETIC DENTISTRY

MEDICAL HISTORY FORM
*** Note: All Responses in BLUE are required!**

NAME: _____ BIRTH DATE: _____ DATE: _____

FOR THE FOLLOWING QUESTIONS, SELECT "YES", "NO", OR A SPECIFIC ITEM. YOUR ANSWERS ARE CONFIDENTIAL.

WHO IS YOUR PRIMARY MEDICAL PHYSICIAN? _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

IN THE PAST 5 YEARS, HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION, OR BEEN HOSPITALIZED?

DESCRIBE: _____

LIST ALL PRESCRIPTION DRUGS, NON-PRESCRIPTION DRUGS OR VITAMINS YOU CURRENTLY TAKE:

_____

ARE YOU ALLERGIC TO:

ASPIRIN/ACETAMINOPHEN/IBUPROFEN	○ Yes ○ No
CODEINE, DEMEROL, OTHER NARCOTICS	○ Yes ○ No
BARBITUATES, SEDATIVES OR SLEEPING PILLS	○ Yes ○ No
PENICILLIN, ERYTHROMYCIN, TETRACYCLINE, OTHER ANTIBIOTICS	○ Yes ○ No
SULFA DRUGS	○ Yes ○ No
LATEX	○ Yes ○ No
METALS OF ANY KIND	○ Yes ○ No
LOCAL ANESTHETIC	○ Yes ○ No
OTHER ALLERGIES (LIST): _____	○ Yes ○ No

PLEASE SELECT "YES" OR "NO" TO INDICATE IF YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING:

HEART CONDITIONS:

ANGINA/CHEST PAIN (UPON EXERTION)	○ Yes ○ No
ARTIFICIAL VALVE(S)	○ Yes ○ No
HEART VALVE PROBLEMS	○ Yes ○ No
HEART ATTACK/DISEASE/SURGERY	○ Yes ○ No
HEART MURMUR	○ Yes ○ No
HIGH/LOW BLOOD PRESSURE	○ Yes ○ No
PACEMAKER	○ Yes ○ No
RHEUMATIC FEVER	○ Yes ○ No
INFECTIVE (BACTERIAL) ENDOCARDITIS	○ Yes ○ No

LIVER PROBLEMS:

LIVER DISEASE	○ Yes ○ No
HEPATITIS ○ A ○ B ○ C ○ D ○ E	○ Yes ○ No

ONCOLOGIC PROBLEMS/TREATMENT:

CANCER (TYPE): _____	○ Yes ○ No
CHEMOTHERAPY	○ Yes ○ No
RADIATION THERAPY	○ Yes ○ No

THYROID/PANCREAS/KIDNEY PROBLEMS:

HYPERTHYROIDISM	○ Yes ○ No
HYPOTHYROIDISM	○ Yes ○ No
DIABETES TYPE I OR II	○ Yes ○ No
SLOW HEALING	○ Yes ○ No
KIDNEY DISEASE	○ Yes ○ No

BACTERIAL AND VIRAL INFECTIONS/STD/STI:

CHICKEN POX/SHINGLES	○ Yes ○ No
ORAL HERPES (COLD SORES)	○ Yes ○ No
OTHER STD/STI: _____	○ Yes ○ No

BLOOD DISORDERS:

HEMOPHILIA	○ Yes ○ No
EXCESSIVE BLEEDING	○ Yes ○ No
ANEMIA	○ Yes ○ No
BLOOD TRANSFUSION	○ Yes ○ No

RESPIRATORY PROBLEMS:

ASTHMA	○ Yes ○ No
HAY FEVER	○ Yes ○ No
SINUS PROBLEMS	○ Yes ○ No
LUNG PROBLEMS	○ Yes ○ No
SHORTNESS OF BREATH	○ Yes ○ No
TUBERCULOSIS	○ Yes ○ No
EMPHYSEMA/COPD	○ Yes ○ No

DIGESTIVE PROBLEMS:

ACID REFLUX, G.E.R.D., HYPERACIDITY	○ Yes ○ No
ULCER(S)	○ Yes ○ No
WEIGHT LOSS	○ Yes ○ No
WEIGHT GAIN	○ Yes ○ No

JOINT PROBLEMS:

ARTHRITIS	○ Yes ○ No
BACK PROBLEMS	○ Yes ○ No
ARTIFICIAL JOINT/JOINT REPLACEMENT	○ Yes ○ No

NERVOUS PROBLEMS:

EPILEPSY	○ Yes ○ No
DIZZINESS	○ Yes ○ No
NEUROLOGICAL DISORDER(S)	○ Yes ○ No
PHYCHOLOGICAL DISORDER(S)	○ Yes ○ No
ANOREXIA/BULIMIA	○ Yes ○ No

IMMUNE SYSTEM PROBLEMS:

HIV	○ Yes ○ No
AIDS	○ Yes ○ No
AUTOIMMUNE DISEASE: _____	○ Yes ○ No

SUBSTANCE USE:

ALCOHOL ABUSE	○ Yes ○ No
TOBACCO (SMOKING OR CHEWING)	○ Yes ○ No
MARIJUANA (SMOKING, EDIBLES, ETC.)	○ Yes ○ No
OTHER SUBSTANCES: _____	○ Yes ○ No

DO YOU HAVE, OR HAVE YOU HAD, ANY OTHER MEDICAL CONDITIONS THAT WERE NOT ADDRESSED ABOVE?

_____

DENTAL HISTORY
*** Note: All Responses in BLUE are required!**

PLEASE SELECT "YES" OR "NO" AS TO WHETHER YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

ORAL TISSUES AND CONDITIONS:

BAD BREATH/HALITOSIS	○ Yes ○ No
CANKER SORES IN MOUTH	○ Yes ○ No
GROWTHS/BLISTERS/SORES IN MOUTH	○ Yes ○ No
BLEEDING GUMS	○ Yes ○ No
PERIODONTAL (GUM) DISEASE	○ Yes ○ No

TMJ SYMPTOMS AND TREATMENT:

FREQUENT HEADACHES/NECKACHES	○ Yes ○ No
CLICKING OR POPPING JAW	○ Yes ○ No
TIRED, SORE OR PAINFUL JAW JOINT/TMJ	○ Yes ○ No
PAIN AROUND EARS/TEMPLES	○ Yes ○ No
CLENCHING OR GRINDING OF TEETH	○ Yes ○ No
TMJ TREATMENT	○ Yes ○ No
NIGHTGUARD/NTI	○ Yes ○ No

RESPIRATION RELATED:

DRY MOUTH	○ Yes ○ No
MOUTH BREATHING	○ Yes ○ No
SNORING	○ Yes ○ No
SLEEP APNEA	○ Yes ○ No
C-PAP MACHINE	○ Yes ○ No

TRAUMA, TREATMENT AND APPLIANCES:

INJURY TO FACE/JAW: _____	○ Yes ○ No
BITEGUARD/SPORTSGUARD	○ Yes ○ No
ORTHODONTICS (BRACES, INVISALIGN, ETC.)	○ Yes ○ No
ORAL SURGERY: _____	○ Yes ○ No
PARTIAL/FULL DENTURE(S)	○ Yes ○ No

TOOTH ISSUES:

PAIN WITH CHEWING	○ Yes ○ No
FOOD PACKING BETWEEN TEETH	○ Yes ○ No
BROKEN TOOTH OR FILLING	○ Yes ○ No
SENSITIVITY TO: HOT, COLD, SWEET, BITING	○ Yes ○ No
VAGUE ACHE/TOOTHACHE	○ Yes ○ No
SWELLING	○ Yes ○ No
LOOSE TOOTH	○ Yes ○ No

TREATMENT CONSIDERATIONS:

DENTAL ANXIETY	○ Yes ○ No
EXCESSIVE GAG REFLEX	○ Yes ○ No
HARD TO GET NUMB	○ Yes ○ No
CLAUSTROPHOBIC	○ Yes ○ No
DIFFICULTY OPENING MOUTH	○ Yes ○ No

LAST VISIT TO DENTIST: _____ FOR: _____

LAST DENTAL HYGIENE APPOINTMENT: _____ WHERE: _____

DO YOU HAVE RECORDS/XRAYS AT ANOTHER OFFICE THAT WE CAN GET FOR YOU? _____

WHAT IS YOUR PRIMARY REASON FOR SEEKING DENTAL TREATMENT TODAY?

_____

WHAT DO YOU WISH YOU COULD CHANGE ABOUT YOUR TEETH?

_____

WHAT HAVE YOU LIKED ABOUT ANY DENTAL OFFICE YOU'VE VISITED IN THE PAST?

WHAT HAVE YOU LIKED LEAST ABOUT ANY OTHER OFFICE YOU'VE BEEN TO?

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICATIONS CHANGE, I WILL INFORM MY DENTIST AT MY NEXT APPOINTMENT.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT.

CASH CHECK CREDIT CARD CARECREDIT DOCPAY SPRINGSTONE

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices.

You may refuse to sign this acknowledgement

Print Name _____ Date: _____

Signature _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ An emergency situation prevented us from obtaining acknowledgement

___Other_____

Employee Name _____ Date _____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

THE INFORMATION YOU HAVE PROVIDED WILL HELP US SERVE YOUR DENTAL NEEDS MORE EFFECTIVELY AND EFFECIENTLY. IF YOU HAVE ANY QUESTIONS AT ANYTIME, PLEASE ASK- WE ARE ALWAYS HAPPY TO HELP.