Northern Smiles
DENTISTRY & ORTHODONTICS

Medical History

Patient Name_____ **Birth Date** _____**Date**_____

Check all of the following that you may have had in the past or that currently apply to you:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial/Orthopedic Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disease
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Dental Implants
- ☐ Diabetes: A1C _____
- ☐ Drug Addiction
- ☐ Elevated Cholesterol
- ☐ Emphysema
- ☐ Epilepsy Or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness Spells
- ☐ Frequent Headaches
- ☐ Gastric Bypass surgery
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack_____
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A, B, or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives Or Rash
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble/Infections
- ☐ Sleep Apnea-CPAP?_____
- ☐ Sores or Growths in mouth
- ☐ Stroke_____
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors Or Growths
- ☐ Ulcers
- ☐ Other_____

Are you allergic or have you reacted adversely to any of the following medications?

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin/Amoxicillin
- ☐ Percodan
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Valium

☐ Other _____

Have you ever taken any the following medications? Provide Start and Stop date

- ☐ Actonel _____
- ☐ Alentronate _____
- ☐ Aredia _____
- ☐ Boniva _____
- ☐ Fosamax _____
- ☐ Reclast _____
- ☐ Risedronate _____
- ☐ Zometa _____
- ☐ Prolina/Denosumab_____
- ☐ Herbal Supplements_____
- ☐ Ibuprofen_____
- ☐ NSAIDs _____

Are you currently taking any medications? If yes please list:_____

_____

Do you need Antibiotics prior to receiving Dental Care? If so, what type/dosage? _____

Do you take Coumadin or Plavix or any other blood thinner? If yes, do you know your typical INR?_____

How would you describe your present health (circle one): Excellent / Good / Fair / Poor / Don't know

When was your last visit with your Primary Care Physician? _____

Are you currently under a physician's care? If yes please list for what:_____

Has there been any change in your general health in the past year? If yes, please explain: _____

_____

Have you ever had any serious illness, hospitalization or condition not listed above in the last 5 years? If yes please describe:

_____

What is your current weight? _____What is your height ?_____

Is there a history of diabetes in your family? If yes, who:_____

Are you a past or present smoker/vapor? Yes/ No If yes, how many Cigarettes/Cigars/mg per day_____Do you Chew Tobacco? Yes/ No

Do you have any history of substance abuse or do you currently use recreational drugs? Yes / No

For Women, Check All That Are Appropriate:

☐ I Am Pregnant/Trying to get pregnant ☐ I Am Nursing ☐ I Am Taking Birth Control Pills

The above information on this form has been accurately answered and is true to the best of my knowledge. I understand that providing incorrect information can be dangerous to my or the patient's health. I understand that it is my responsibility to inform Northern Smiles Dentistry and Orthodontics and the rendering Dentist of the dental office of any changes in my or the patient's medical status.

Patient/Guardian signature:_____ **Date**_____

Blood Pressure/Heart Rate_____

Doctor's Signature:_____ Date_____

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DENTISTRY & ORTHODONTICS

Dental History

Patient Name_____ **Birth Date** _____**Date**_____

Date of Last Dental Cleaning?_____ What is the frequency of cleanings?_____

How Many Times a Day do you Brush Your Teeth?_____ How Many Times a Day do you Floss?_____

What Type of Tooth Brush do you Use? _____

Do you use a water Pik? Yes / No

Please Rate Your Current Dental Health: Excellent Good Fair Poor

How Would you Rate Your Smile: Excellent Good Fair Poor

Are Your Teeth Sensitive to: Heat Cold Sweets Pressure Brushing Flossing

Yes	**No**	**(If Yes, Please Explain)**
☐	☐	Do you experience dry mouth?
☐	☐	Do your Gums Bleed?
☐	☐	Would you prefer to be Sedated for Dental Treatment?
☐	☐	Are you concerned with Tooth Loss or Wearing Dentures?
☐	☐	Have you ever had Orthodontic Treatment (Braces)?
☐	☐	Have you ever had trouble getting Numb and/or had Reactions to Local Anesthetic?
☐	☐	Have you noticed any Loose and/or Shifting Teeth?
☐	☐	Have you noticed any Bad Tastes or Bad Breath?
☐	☐	Have any of your family members had Advanced Gum Disease, Wear Partials or Dentures?
☐	☐	Do you have any Clicking, Popping, and/or Discomfort in the Jaw?
☐	☐	Do you Clench and/or Grind Your Teeth?
☐	☐	Do you wear a Nightguard or Appliance? _____
☐	☐	Are you experiencing any discomfort? _____
☐	☐	Have you ever had Periodontal (Gum) treatment? _____
☐	☐	Have you ever had Deep Cleaning (Scaling with Local Anesthesia)?_____
☐	☐	Have you had problems associated with previous Dental Treatment? _____

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Patient/Guardian signature:_____**Date**_____