

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:

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

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

- | | | | |
|--------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Percodan | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Other _____ | | | |

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Actonel _____ | <input type="checkbox"/> Boniva _____ | <input type="checkbox"/> Risedronate _____ |
| <input type="checkbox"/> Alendronate _____ | <input type="checkbox"/> Fosamax _____ | <input type="checkbox"/> Zometa _____ |
| <input type="checkbox"/> Aredia _____ | <input type="checkbox"/> Reclast _____ | <input type="checkbox"/> Prolina/Denosumab _____ |
| <input type="checkbox"/> Herbal Supplements _____ | <input type="checkbox"/> Ibuprofen _____ | <input type="checkbox"/> 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? _____ If yes, how many Cigarettes/Cigars/mg per day _____ Do you Chew Tobacco?

Do you have any history of substance abuse or do you currently use recreational drugs?

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 _____

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) |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience dry mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your Gums Bleed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Would you prefer to be Sedated for Dental Treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you concerned with Tooth Loss or Wearing Dentures? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had Orthodontic Treatment (Braces)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had trouble getting Numb and/or had Reactions to Local Anesthetic? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you noticed any Loose and/or Shifting Teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you noticed any Bad Tastes or Bad Breath? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any of your family members had Advanced Gum Disease, Wear Partials or Dentures? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any Clicking, Popping, and/or Discomfort in the Jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you Clench and/or Grind Your Teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear a Nightguard or Appliance? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you experiencing any discomfort? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had Periodontal (Gum) treatment? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had Deep Cleaning (Scaling with Local Anesthesia)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had problems associated with previous Dental Treatment? _____ |

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** _____