

TOTAL CARE DENTAL

MEDICAL HISTORY

DATE ____/____/____

Name: _____
Title First MI Last Nickname

Date of Birth: ____/____/____ Social Security Number: ____-____-____ Height: ____ Weight: ____

Who may we thank for referring you to us (How did you hear about us?) _____

If you are completing this form for another person, what is your relationship to that person? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS. IF YOU NEED HELP, ASK THE RECEPTIONIST.

1. Chief Complaint/Reason for Being Here: _____

2. Last Dental Visit and Reason for Visit: _____

3. Past Dental History (check all previous services received from dentistry):

- | | |
|--|--|
| <input type="checkbox"/> Dental exam with x-rays | <input type="checkbox"/> Complete dentures |
| <input type="checkbox"/> Tooth extraction or oral surgery | <input type="checkbox"/> Periodontal treatment (gum treatment) |
| <input type="checkbox"/> Restorations (fillings) | <input type="checkbox"/> Endodontic treatment (root canal treatment) |
| <input type="checkbox"/> Partial dentures (removable) | <input type="checkbox"/> Orthodontic treatment (braces) |
| <input type="checkbox"/> Crown and bridgework (fixed) | |
| <input type="checkbox"/> Special diagnostic exam – Explain _____ | |

4. Previous dental experiences

- Unpleasant experience with dentist(s) in past _____
- Pleased with previous dental experience

5. Self Analysis of Oral Tissue Health

- | | |
|---|--|
| <input type="checkbox"/> Bad teeth (cavities) | <input type="checkbox"/> "Dry mouth" (not enough saliva) |
| <input type="checkbox"/> Crooked teeth | <input type="checkbox"/> Bleeding mouth or gums (underline which) |
| <input type="checkbox"/> Bad gums | <input type="checkbox"/> Swelling in mouth or jaws on occasion (underline which) |
| <input type="checkbox"/> Bad bite; bite feels off | <input type="checkbox"/> Loose or drifting teeth |
| <input type="checkbox"/> Frequent sores in mouth or on lips | <input type="checkbox"/> Food catches between teeth |
| <input type="checkbox"/> Halitosis (bad breath) – (Have, concerned about) | <input type="checkbox"/> Bad taste in mouth |
| <input type="checkbox"/> Teeth painful to hot, cold, sweets (underline which) | <input type="checkbox"/> Severe toothaches |
| <input type="checkbox"/> Teeth discolored, yellowish | |
| <input type="checkbox"/> Other signs or symptoms, Describe _____ | |

6. Oral Habits

- Do you use any tobacco products?
- Do you drink alcohol?
- Do you chew gum?

Please do not write in space below.

CARDIOVASCULAR

YES NO

- Have you ever been told you have heart trouble?
- Have you ever been told you have high or low blood pressure?
- Have you had rheumatic fever?
- Do you have a heart murmur as a consequence of rheumatic fever or prolapsed mitral valve (underline which)?
- Have you ever been told you have a heart murmur of any cause?
- Have you had a stroke?
- Do your ankles become easily swollen?
- Do you suffer from angina pectoris (chest and left arm pain)?

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Please do not write in space below.

SPECIAL SENSES

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had earaches or eye problems? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Have you noticed any changes in your sense of taste or smell? |

RESPIRATORY

- | | YES | NO | |
|----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have the flu or a cold more than twice a year? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma, hayfever, sinusitis, or frequent sore throats? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had pneumonia or a lung infection? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had tuberculosis? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a chronic cough or cough up blood? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have bronchitis or emphysema? |

NEUROLOGIC

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been under psychiatric care? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have numbness or tingling feelings anywhere? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a nervous breakdown? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Are you anxious or depressed frequently? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Have you been told you have epilepsy or seizures? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have Parkinson's disease? |

ENDOCRINE

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have diabetes? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Does any member of your family have diabetes? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have thyroid problems or take thyroid tablets? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any other gland problems? |

GASTROINTESTINAL

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had jaundice, liver trouble or hepatitis? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have stomach or peptic ulcers? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent or prolonged diarrhea or constipation? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Have you gained or lost much weight recently? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you regurgitate blood? |

GENITOURINARY

- | | YES | NO | |
|----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told you have kidney or bladder trouble? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any sexually transmitted diseases (syphilis, gonorrhea, genital herpes, HIV infection, AIDS)? |

HEMATOLOGIC

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had anemia? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have leukemia? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had excessive bleeding following tooth removal or cuts, or have you had frequent nose bleeds? |

IMMUNOLOGIC

- | | YES | NO | |
|----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Are you sensitive or allergic to any medications? (penicillin, sulfa drugs, aspirin, etc.) |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to any foods, metals, pollens or latex (rubber)? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a defective immune system? |

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MUSCULOSKELETAL

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Are your joints often painfully swollen or do you have arthritis? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have back problems? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had more than one fracture or dislocation? |

SURGERY - ANESTHESIA

- | | YES | NO | |
|----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had an operation? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had anesthesia? _____Local _____General |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told not to take novocaine or any other medication? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told you have cancer or a tumor? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an organ or bone marrow transplant? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Are you using any recreational drugs or substances? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Active or recovering from substance abuse? |

WOMEN

- | | YES | NO | |
|----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Are you taking birth control pills or have Norplant? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? Expected delivery date _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Are you breast feeding? |

FACIAL PAIN HISTORY

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had severe pains of the face or head? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you suffer from headache, eye pain or migraine? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ear pain or pain in front of your ears? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does it hurt when you chew? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your jaw make a noise that bothers you or others? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Does the pain or discomfort interfere with your work or other activities? |

IMPLANTS

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a prosthetic (artificial) heart valve? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had vascular or cardiac repair with synthetic materials? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a vascular shunt (hemodialysis or drug therapy)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any prosthetic joints (hip, knee, ankle, shoulder, finger)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a pacemaker? |

Name of Primary Physician: _____ Phone No: _____

List of All Medications Currently Taking: _____

I verify that, to the best of my knowledge, the above health history is correct.

Patient or Guardian Signature