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):
   - ☐ Dental exam with x-rays
   - ☐ Tooth extraction or oral surgery
   - ☐ Restorations (fillings)
   - ☐ Partial dentures (removable)
   - ☐ Crown and bridgework (fixed)
   - ☐ Special diagnostic exam – Explain _____
   - ☐ complete dentures
   - ☐ Periodontal treatment (gum treatment)
   - ☐ Endodontic treatment (root canal treatment)
   - ☐ Orthodontic treatment (braces)

4. Previous dental experiences
   - ☐ Unpleasant experience with dentist(s) in past _____
   - ☐ Pleased with previous dental experience

5. Self Analysis of Oral Tissue Health
   - ☐ Bad teeth (cavities)
   - ☐ Crooked teeth
   - ☐ Bad gums
   - ☐ Bad bite; bite feels off
   - ☐ Frequent sores in mouth or on lips
   - ☐ Halitosis (bad breath) – (Have, concerned about)
   - ☐ Teeth painful to hot, cold, sweets (underline which)
   - ☐ Teeth discolored, yellowish
   - ☐ Other signs or symptoms, Describe_____
   - ☐ "Dry mouth" (not enough saliva)
   - ☐ Bleeding mouth or gums (underline which)
   - ☐ Swelling in mouth or jaws on occasion (underline which)
   - ☐ Loose or drifting teeth
   - ☐ Food catches between teeth
   - ☐ Bad taste in mouth
   - ☐ Severe toothaches

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

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SPECIAL SENSES

	YES	NO	
1.	☐	☐	Have you had earaches or eye problems?
2.	☐	☐	Have you noticed any changes in your sense of taste or smell?

RESPIRATORY

	YES	NO	
1.	☐	☐	Do you have the flu or a cold more than twice a year?
2.	☐	☐	Do you have asthma, hayfever, sinusitis, or frequent sore throats?
3.	☐	☐	Have you had pneumonia or a lung infection?
4.	☐	☐	Have you had tuberculosis?
5.	☐	☐	Do you have a chronic cough or cough up blood?
6.	☐	☐	Do you have bronchitis or emphysema?

NEUROLOGIC

	YES	NO	
1.	☐	☐	Have you ever been under psychiatric care?
2.	☐	☐	Do you have numbness or tingling feelings anywhere?
3.	☐	☐	Have you ever had a nervous breakdown?
4.	☐	☐	Are you anxious or depressed frequently?
5.	☐	☐	Have you been told you have epilepsy or seizures?
6.	☐	☐	Do you have Parkinson's disease?

ENDOCRINE

	YES	NO	
1.	☐	☐	Do you have diabetes?
2.	☐	☐	Does any member of your family have diabetes?
3.	☐	☐	Do you have thyroid problems or take thyroid tablets?
4.	☐	☐	Do you have any other gland problems?

GASTROINTESTINAL

	YES	NO	
1.	☐	☐	Have you had jaundice, liver trouble or hepatitis?
2.	☐	☐	Do you have stomach or peptic ulcers?
3.	☐	☐	Do you have frequent or prolonged diarrhea or constipation?
4.	☐	☐	Have you gained or lost much weight recently?
5.	☐	☐	Do you regurgitate blood?

GENITOURINARY

	YES	NO	
1.	☐	☐	Have you ever been told you have kidney or bladder trouble?
2.	☐	☐	Have you had any sexually transmitted diseases (Syphilis, Gonorrhea, Genital herpes, HIV infection, AIDS)?

HEMATOLOGIC

	YES	NO	
1.	☐	☐	Have you had anemia?
2.	☐	☐	Do you have leukemia?
3.	☐	☐	Have you ever had excessive bleeding following tooth removal or cuts, or have you had frequent nose bleeds?

IMMUNOLOGIC

	YES	NO	
1.	☐	☐	Are you sensitive or allergic to any medications? (penicillin, sulfa drugs, aspirin, etc.)
2.	☐	☐	Are you allergic to any foods, metals, pollens or latex (rubber)?
3.	☐	☐	Do you have a defective immune system?

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MUSCULOSKELETAL

	YES	NO	
1.	☐	☐	Are your joints often painfully swollen or do you have arthritis?
2.	☐	☐	Do you have back problems?
3.	☐	☐	Have you had more than one fracture or dislocation?

SURGERY - ANESTHESIA

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

WOMEN

	YES	NO	
1.	☐	☐	Are you taking birth control pills or have Norplant?
2.	☐	☐	Are you pregnant? Expected delivery date _____
3.	☐	☐	Are you breast feeding?

FACIAL PAIN HISTORY

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

IMPLANTS

	YES	NO	
1.	☐	☐	Do you have a prosthetic (artificial) heart valve?
2.	☐	☐	Have you had vascular or cardiac repair with synthetic materials?
3.	☐	☐	Do you have a vascular shunt (hemodialysis or drug therapy)?
4.	☐	☐	Do you have any prosthetic joints (hip, knee, ankle, shoulder, finger)?
5.	☐	☐	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