FOREST ACRES DENTISTRY

Patient Information

Patient Name: _____ Date: _____
Last *First* *MI*

□ Male □ Female □ Married □ Single □ Child □ Other _____

Social Security #: _____ Date of Birth: _____ Email: _____

Phone - Home: _____ Cell: _____ Work: _____, ext.: _____

Address: _____
Street *City* *State* *Zip Code*

Health Information

Medical History

1) Are you under the care of a physician? Y / N If yes, provider's name: _____ phone: _____
2) What is the impression of your overall health? □ Excellent □ Good □ Fair □ Poor
3) Have you been hospitalized or had surgery in the last 5 years? □ Yes □ No
4) Do you have or have you ever had any of the following? Please check those that apply:

□ **Yes** □ **No 1) Blood Disease (e.g. anemia, hemophilia), If yes:**
- a) Do you bruise easily? □ Yes □ No
- b) Do you bleed excessively or for a long time if you cut yourself? □ Yes □ No

□ **Yes** □ **No 2) High Blood Pressure**

□ **Yes** □ **No 3) Heart Disease**
- □ Heart attack; How many? _____ Any within the past 6 months? □ Yes □ No
- □ Arrhythmia
- □ Congestive heart failure
- □ Angina: How often? _____ Any chest pain at rest? □ Yes □ No
- □ History of bacterial endocarditis

□ **Yes** □ **No 4) Have you had or are you scheduled for heart surgery? If yes, please specify**
- □ Artificial heart valve replacement
- □ Bypass (CABG)
- □ Stent
- □ Correction of congenital heart defect
- □ Pacemaker
- □ Defibrillator

□ **Yes** □ **No 5) Vascular Disease**
- □ Aneurysm
- □ High cholesterol

□ **Yes** □ **No 6) Stroke or TIA**
How many? _____ Any within the past 6 months? □ Yes □ No

□ **Yes** □ **No 7) Lung problems**
- □ Asthma
- □ Chronic bronchitis
- □ Emphysema
- □ Do you routinely use an inhaler?

□ **Yes** □ **No 8) Diabetes**, If yes: □ Type 1 □ Type 2

□ **Yes** □ **No 9) Liver Problems** (e.g. jaundice, cirrhosis, ascites)

□ **Yes** □ **No 10) Thyroid disease**, If yes: □ Hyperthyroidism □ Hypothyroidism

□ **Yes** □ **No 11) Kidney Failure**

□ **Yes** □ **No 12) Autoimmune diseases** (e.g. lupus, rheumatoid arthritis, inflammatory bowel disease, multiple sclerosis)

□ **Yes** □ **No 13) Arthritis**, If yes: □ Osteoarthritis □ Rheumatoid arthritis

□ **Yes** □ **No 14) Have you ever had a total joint replacement? If so, when? _____**

□ **Yes** □ **No 15) Mental health**

- □ Anxiety
- □ Depression
- □ Bioplar
- □ Schizophrenia
- □ Post traumatic stress
- □ Obsessive / compulsive
- □ Dementia

□ **Yes** □ **No 16) Epilepsy or seizures**

□ **Yes** □ **No 17) Do you tend to faint easily?**

□ **Yes** □ **No 18) Cancer or tumors**, If yes, what type? _____

- Did you receive radiation therapy? □ Yes □ No
- Chemotherapy? □ Yes □ No

□ **Yes** □ **No 19) Infectious diseases**

- □ Hepatitis B
- □ Hepatitis C
- □ HIV / AIDS
- □ Tuberculosis

□ **Yes** □ **No 20) Have you had or are you scheduled to have an organ transplant or bone marrow transplant?**

□ **Yes** □ **No 21) Spleenectomy. If yes:** Was it more than 2 years ago? □ Yes □ No

□ **Yes** □ **No 22) For Women – are you pregnant or do you think you might be pregnant?** If yes, # of weeks: _____

□ **Yes** □ **No 23) Do you have any other medical problems or conditions not listed here?**_____

_____

5) Allergies

Are you allergic to or have you had a reaction to any of the following? If yes, specify reaction.

□ **Yes** □ **No 1) Antibiotics** (Penicillins, Clindamycin, Cephalosporins, Erythromycins, etc.) _____

□ **Yes** □ **No 2) Pain medications** (Aspirin, Tylenol, Motrin, Aleve, Codeine, Demerole, etc.) _____

□ **Yes** □ **No 3) Local anesthetics or their preservatives** (sulfites) _____

□ **Yes** □ **No 4) Metals or jewelry** (nickel or chrome) _____

6) Medications or Supplements

□ **Yes** □ **No 1) Do you currently take any medications or vitamins?** If yes, please list _____

_____

□ **Yes** □ **No 2) Do you take a blood thinner?**

□ **Yes** □ **No 3) Have you taken steroids, now or in the last 30 days?**

□ **Yes** □ **No 4) Do you now or have you <u>ever</u> taken Bisphosphonates (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, etc.)?** If yes, what type? _____ When taken? _____

7) Social History

□ **Yes** □ **No 1) Do you use any tobacco products**? If yes, what and how much per day? _____

□ **Yes** □ **No 2) Do you consume more than 2 alcoholic drinks per day?**

□ **Yes** □ **No 3) Within the past year have you used recreational drugs?**

□ **Yes** □ **No 4) Within the past year have you misused prescriptions drugs?**

<u>Dental History</u>

1) **What is your primary dental concern?** _____

2) **Do you have any of the following?** Please check those that apply:

- □ Bleeding/sensitive gums
- □ Sensitivity to hot/cold
- □ Sensitivity to sweets
- □ Broken fillings
- □ Food trapping between teeth
- □ Loose teeth
- □ Sensitivity to biting
- □ Sores in the mouth
- □ Bad breath

3) TMJ and Orofacial System

- □ **Yes** □ **No** **1) Does your jaw every make a click, pop, or grinding noise?**
- □ **Yes** □ **No** **2) Do you clench or grind your teeth?**
- □ **Yes** □ **No** **3) Has your jaw <u>ever</u> locked open or closed?**
- □ **Yes** □ **No** **4) Do you have frequent headaches and/or neck pain?**
- □ **Yes** □ **No** **5) Does your bite ever feel "off" or does your bite feel like it is changing?**
- □ **Yes** □ **No** **6) Do you have a bite splint or night guard?** If so, do you wear it? Y / N
- □ **Yes** □ **No** **7) Do you have multiple broken or chipped teeth?**
- □ **Yes** □ **No** **8) Have you ever been diagnosed with sleep apnea?** If so, do you use a CPAP machine? Y / N

4) Do you have anxiety or fear related to dental treatment? Y / N
5) Do you require sedation or nitrous oxide for dental treatment? Y / N
6) Have you ever had any complications following dental treatment? Y / N
7) Have you been told that you require antibiotic pre-medication for dental procedures? Y / N
8) Do you have any history of oral cancer or intra-oral biopsy? Y / N
9) Is there anything about your teeth that you want to change? _____

To the best of my knowledge, all the preceding answer and information are true and correct. If I have changes in my health, I will inform the doctor at the next appointment.

Patient / Guardian Signature: _____ Date: _____