

# SENSITIVE CARE

COSMETIC & FAMILY DENTISTRY

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_

Although dental personnel primarily treat area in and around your mouth, your mouth is part of your entire body. Health problems that you maybe have, or medication that you may be taking, could have an important interrelationship with dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No *Please list:* \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No
- Do you use tobacco?  Yes  No
- Are you on a special diet?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

Do you have, or have you had, any of the following?

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/ HIV Positive      | <input type="checkbox"/> Cold Sores/Fever Blisters   | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease     | <input type="checkbox"/> Congenital Heart Disorder   | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Convulsions                 | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Medicine          | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Diabetes<br>a1c level _____ | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout          | <input type="checkbox"/> Drug Addiction              | <input type="checkbox"/> Heart Murmur*         | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Dialysis                    | <input type="checkbox"/> Heart Pace Maker*     | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint*       | <input type="checkbox"/> Easily Winded               | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Pain in Jaw Joints     | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Epilepsy or Seizures        | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Parathyroid Disease    | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Excessive Bleeding          | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem       | <input type="checkbox"/> Excessive Thirst            | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Radiation Treatments   | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Fainting Spells/Dizziness   | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Recent Weight Loss     | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Frequent Cough              | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Renal Dialysis         | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Frequent Diarrhea           | <input type="checkbox"/> Hive or Rash          | <input type="checkbox"/> Rheumatic Fever*       | <input type="checkbox"/> Yellow Jaundice            |
| <input type="checkbox"/> Chest Pains             |  | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism             |   |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

\* Condition may require medication

### CONSENT:

- I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
- The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deem fit to provide recommended treatment.
- I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1% finance charge maybe be added to my account, in addition to any collection charges.
- I understand that where appropriate, credit bureau reports may be obtained.
- I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
- I authorize the use of my social security number to file my dental claim.

Patient \_\_\_\_\_ Date \_\_\_\_\_

  
**SENSITIVE CARE**  
 COSMETIC & FAMILY DENTISTRY  
**DENTAL HISTORY**

PATIENT NAME \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Date of last Dental visit? \_\_\_\_\_ Last Dental Cleaning? \_\_\_\_\_ Last Full mouth X-Rays? \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Name of previous Dentist \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you have dental problems now? \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

Do you use a: water-pick, toothpick, electric toothbrush, other? \_\_\_\_\_

Which of the following apply to you?

**Are any of your teeth sensitive to:**

- Hot or cold
- Sweets
- Biting or chewing
- Do you have mouth odors or bad taste
- Cold sores, blisters, other oral lesions

**Do your gums bleed or hurt?**

- Gum pain or bleeding
- Loose teeth or change in bite
- Food caught/stuck between teeth
- Parental history of gum disease
- Parental history of tooth loss
- Shredding Floss

**Do you:**

- Clench/grind teeth (while awake or asleep)
- Bite lips or cheeks regularly
- Hold foreign objects with you teeth (pencils, pipe, pins, nails, fingernails, etc)
- Mouth breathe while awake or asleep
- Have tired jaws, especially morning
- Smoke or chew tobacco
- Snore

**Have you ever had:**

- Orthodontic treatment
- Oral surgery
- Periodontal treatment
- Your teeth ground or the bite adjusted

- A bite plate or mouth guard
  - Had a serious injury to the mouth or head
- If so please describe, including cause:

\_\_\_\_\_

**Have you experienced:**

- Clicking or popping of jaw
- Pain (joint, ear, side of face)
- Difficulty in opening or closing the mouth
- Difficulty in chewing on either side of the mouth
- Headaches, neck aches, or shoulder aches
- Sore muscles (neck, shoulders)

Would you like to keep all of your teeth all of your life?  Yes  No \_\_\_\_\_

Do you feel nervous about having dental treatment? If yes, explain.  Yes  No \_\_\_\_\_

Do you have any concerns about dental treatment? If yes, explain.  Yes  No \_\_\_\_\_

Have you ever had an upsetting dental experience? If yes, explain.  Yes  No \_\_\_\_\_

Do you use more than two pillows to sleep?  Yes  No \_\_\_\_\_

Have you lost or gained more than 10 lbs in the past year? \_\_\_\_\_

Have you been diagnosed with Osteoporosis/Osteopenia? \_\_\_\_\_

Do you take or have you taken Bisphosphonates? \_\_\_\_\_

Is there anything else about having dental treatment that you would like us to know? \_\_\_\_\_

**Who may we contact in case of emergency?** Name \_\_\_\_\_

Relationship \_\_\_\_\_ Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Comments : \_\_\_\_\_  
 \_\_\_\_\_