# Medical History

Patient Name _____ Preferred Name _____

Date of Birth_____ Today's Date _____

**Please check Yes or No if any of the following apply to you:**

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | AIDS | ❑ | ❑ | Emphysema | ❑ | ❑ | Latex Allergy | ❑ | ❑ | Radiation (head/neck) |
| ❑ | ❑ | Allergies (Seasonal) | ❑ | ❑ | Excessive Bleeding | ❑ | ❑ | Liver Disease | ❑ | ❑ | Radiation Treatment |
| ❑ | ❑ | Allergic to Bananas | ❑ | ❑ | Heart Conditions | ❑ | ❑ | Low Blood Pressure | ❑ | ❑ | Respiratory Problems |
| ❑ | ❑ | Anemia | ❑ | ❑ | Heart Lesions (Congenital) | ❑ | ❑ | Lupus | ❑ | ❑ | Rheumatic Fever |
| ❑ | ❑ | Arthritis | ❑ | ❑ | Heart Murmur | ❑ | ❑ | Mitral Valve Prolapse | ❑ | ❑ | Rheumatism |
| ❑ | ❑ | Artificial Heart Valve | ❑ | ❑ | Heart Surgery | ❑ | ❑ | Multiple Sclerosis | ❑ | ❑ | Scarlet Fever |
| ❑ | ❑ | Artificial Joints | ❑ | ❑ | Hepatitis A | ❑ | ❑ | Nervousness/Depression | ❑ | ❑ | Seizures |
| ❑ | ❑ | Asthma | ❑ | ❑ | Hepatitis B | ❑ | ❑ | Osteoperosis/Take Bisphosphonates | ❑ | ❑ | Sinus Problems |
| ❑ | ❑ | Blood Disease | ❑ | ❑ | Hepatitis C | | | | ❑ | ❑ | Special Needs/Disability |
| ❑ | ❑ | Bruise Easily | ❑ | ❑ | Herpes | ❑ | ❑ | Pacemaker | ❑ | ❑ | Stomach Problems |
| ❑ | ❑ | Cancer | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Periodontal Disease | ❑ | ❑ | Stroke |
| ❑ | ❑ | Chemotherapy | ❑ | ❑ | High Cholesterol | ❑ | ❑ | Phen Fen (1 month +) | ❑ | ❑ | Thyroid Disease |
| ❑ | ❑ | Diabetes | ❑ | ❑ | HIV Positive | ❑ | ❑ | Pregnant Currently | ❑ | ❑ | Tuberculosis |
| ❑ | ❑ | Dialysis | ❑ | ❑ | Jaundice | ❑ | ❑ | Prolonged Bleeding | ❑ | ❑ | Ulcers |
| ❑ | ❑ | Dizziness | ❑ | ❑ | Jaw Joint Pain | ❑ | ❑ | Prosthetic Joints | ❑ | ❑ | Venereal Diseases |
| ❑ | ❑ | Drug Addiction | ❑ | ❑ | Kidney Disease | ❑ | ❑ | Psychiatric Treatment | ❑ | ❑ | Other_____ |

**Do you have any of the following drug allergies?**

| | | | |
|---|---|---|---|
| ❑ Aspirin | ❑ Codeine | ❑ Nitrous Oxide | ❑ Valium |
| ❑ Percodan | ❑ Darvon | ❑ Penicillin | ❑ Other |
| ❑ Local Anesthetic | ❑ Erythromycin | ❑ Sulfa | |

Other: _____

**Are you under a physician's care? What for?**

_____

_____

**Blood Pressure Reading:** _____

**Are you taking any medications? What are they?**

| | | |
|---|---|---|
| ❑ Antibiotics or Sulfa Drugs | ❑ Aspirin or Anti-Inflammatory Agent | ❑ Digitalis or Drugs for Heart Trouble |
| ❑ Anticoagulants (Blood Thinners) | ❑ Dilantin or other Anti-Convulsant | ❑ Nitroglycerin |
| ❑ Birth Control Pills | ❑ Hormone Replacement Therapy | ❑ Narcotic Analgesic |
| ❑ Medicine for High Blood Pressure | ❑ Herbal Medications | ❑ Recreational Drugs |
| ❑ Cortisone or Steroids | ❑ Insulin or Similar Drug for Diabetes Control | ❑ Other |
| ❑ Tranquilizers | | |

Other: _____

_____

**Family Physician** _____ **Phone**_____

**Last Physical Exam**_____

**Is there any thing else we should know about your medical or dental health?**

_____

_____

_____

Parkcrest
DENTAL GROUP

# Dental History

Parkcrest
DENTAL GROUP

**Please check any of the following problems that apply to you.**

❑ Sensitivity (hot, cold, sweet) Where? _____

❑ Headaches, earaches, neck pain
❑ Jaw joint pain
❑ Teeth or fillings breaking
❑ Grinding or clenching teeth
❑ Bleeding, swollen or irritated gums
❑ Loose, tipped or shifting teeth
❑ Bad breath

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

❑ Dentures
❑ Partial dentures
❑ Braces
❑ Periodontal (gum) treatments

**Please share the following dates:**

Your last cleaning ___ / ___
Your last oral cancer screening ___ / ___
Your last complete X-Rays ___ / ___

**Name of Previous Dentist** _____

_____
**City State**

_____
**Phone Number**

**What is the most important thing to you about your future smile and dental health?**

_____

_____

**If you could whiten your teeth for a cost anyone could afford, would you do it?** ❑ **Yes** ❑ **No**
**Do you smoke or use chewing tobacco?** ❑ **Yes** ❑ **No**
How much? For how long?

**If I could change my smile, I would:**

❑ Make them whiter
❑ Make them straighter
❑ Close spaces
❑ Replace black metal fillings with tooth colored restorations
❑ Repair chipped teeth
❑ Replace missing teeth
❑ Replace old crowns that don't match
❑ Have a smile makeover

**On a scale of 1 –10, with 10 being the highest rating:**

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

**Why did you leave your previous dentist?**

_____

**What is the most important thing to you about your dental visit today?**

_____

_____

**Print Name** _____

**Signature (Patient or Guardian)** _____ **Date** _____

**Dentist Signature** _____