Dousman FAMILY DENTISTRY

DENTAL / MEDICAL HISTORY

Your name_____ Date: _____

Medical Doctor's name _____ Dr's. phone number _____

Are you under a Doctor's care now? ☐ No ☐ Yes If yes, why? _____

Have you ever been hospitalized? ☐ No ☐ Yes If yes, for what & when? _____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Local Injected Anesthetic ☐ Latex ☐ Other: _____

Are you pregnant? ☐ No ☐ Yes If yes, what week? _____

Have you ever been told by your physician to pre-medicate before dental visits? ☐ No ☐ Yes If yes, with what? _____

Do you smoke? ☐ No ☐ Yes If yes, how much and how many years? _____

Do you use any tobacco products? ☐ No ☐ Yes If yes, specify _____

Check all that apply

☐Acid Reflux	☐Cancer	☐Excessive Thirst	☐Herpes	☐Rheumatism
☐AIDS (HIV)	☐Chemotherapy/Radiation	☐Fainting or dizziness	☐High Blood Pressure	☐Shortness of Breath
☐Allergies	☐Chest Pain	☐Glaucoma	☐Hypoglycemia	☐Sickle Cell Anemia
☐Anemia	☐Cognitive Disorder	☐Hay Fever	☐Kidney Trouble	☐Sinus trouble
☐Arthritis/Gout	☐Cold Sores	☐Heart Attack,Date _____	☐Liver Disease	☐Stroke, Date _____
☐Artificial Heart Valve	☐Congenital Heart Lesion	☐Heart Pacemaker	☐Low Blood Pressure	☐Swelling of ankles/feet
☐Artificial Joints	☐Cortisone Medication	☐Heart Surgery	☐Lung Disease	☐Thyroid Disease
☐Asthma	☐Diabetes	☐Hemophilia	☐Nervousness	☐Tuberculosis
☐Biphosphonates	☐Drug Addiction	☐Hepatitis A	☐Parathyroid Disease	☐ Venereal Disease
☐Blood Disease/Disorder	☐Emphysema	☐Hepatitis B	☐Psychiatric Care	☐ X-Ray/Cobalt Tx
☐Bruise easily	☐Epilepsy/Seizures	☐Hepatitis C	☐Recent weight loss	

Do you have any other medical conditions that may not be listed above? ☐ No ☐ Yes If yes, what? _____

Are you taking any medications? ☐ No ☐ Yes If yes, please list the medications you are taking and why you are taking them:

MEDICATION	REASON
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DENTAL HISTORY

Purpose of this visit? _____

How long since your last dental visit? _____

What was done at that time? _____

Your previous dentist's name and location: _____

How did you find out about our office? ☐ Internet ☐ Phone book ☐ Friend/co-worker ☐ Other: _____

Referred by: _____

When was the last time your teeth were cleaned? _____

Have you made regular dental visits? ☐ Yes ☐ No If yes, how often? _____

When were dental x-rays last taken? _____

Are your teeth sensitive to hot or cold?	☐ Yes	☐ No	Do you clench or grind your teeth?	☐ Yes	☐ No
Do you regularly have a dry mouth?	☐ Yes	☐ No	Does your jaw click or pop?	☐ Yes	☐ No
Have you ever been treated for gum disease?	☐ Yes	☐ No	Does food get caught between your teeth?	☐ Yes	☐ No
Have you been told you have perio/gum disease?	☐ Yes	☐ No	Do you have dental implants?	☐ Yes	☐ No
Do your gums bleed?	☐ Yes	☐ No	Do you have REMOVABLE partials or dentures?	☐ Yes	☐ No
Have you had orthodontic treatments in past?	☐ Yes	☐ No	Do you have jaw pain?	☐ Yes	☐ No

Signature: _____ Date: _____