Forest Creek Family Dental Date_____

Patient Name_____ Update Phone_____

Patient Date of Birth_____ Update Address_____

MEDICAL HISTORY_____

1. Are you in good health?.....**Yes / No**; My last physical examination was on_____

2. Has there been any change in your general health within the past year?.....**Yes / No**

4. Are you now under the care of a physician?....**Yes / No**; If so, what is being treated?_____

5. Name and Phone of Physician_____

6. Have you had any serious illness/operation?...**Yes / No**; If so, what?_____

7. Have you been hospitalized within the past five (5) years?.....**Yes / No**

If so, what was the problem?_____

8. Have you ever had a surgical procedure resulting in the placement of screws, pins, or plates?.....**Yes / No**

If so, have you ever been told you need an antibiotic before an dental procedures?.....**Yes / No**

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

O **Yes** O **No**	AIDS/HIV Positive	O **Yes** O **No**	Glaucoma	O **Yes** O **No**	Mouth Ulcers
O **Y** O **N**	Allergy/Hay Fever	O **Y** O **N**	Heart Attack/Failure	O **Y** O **N**	Persistent Cough
O **Y** O **N**	Arthritis	O **Y** O **N**	Heart Murmur	O **Y** O **N**	Psychiatric Problems
O **Y** O **N**	Artificial Joint/Valve	O **Y** O **N**	Heart Pacemaker	O **Y** O **N**	Radiation Treatment
O **Y** O **N**	Asthma	O **Y** O **N**	Heart Trouble/Disease	O **Y** O **N**	Rheumatism
O **Y** O **N**	Blood Disease/Transfusion	O **Y** O **N**	Hepatitis/Jaundice	O **Y** O **N**	Sinus Trouble
O **Y** O **N**	Breathing Problems	O **Y** O **N**	High Cholesterol	O **Y** O **N**	Stomach Problems
O **Y** O **N**	Cancer/Chemotherapy	O **Y** O **N**	High Blood Pressure	O **Y** O **N**	Stroke
O **Y** O **N**	Chest Pain	O **Y** O **N**	Hives/Rash/Eczema	O **Y** O **N**	Swelling of Limbs
O **Y** O **N**	Congenital Heart Disease	O **Y** O **N**	Kidney Disease	O **Y** O **N**	Thyroid Disease
O **Y** O **N**	Diabetes	O **Y** O **N**	Liver Disease	O **Y** O **N**	Tuberculosis (TB)
O **Y** O **N**	Difficulty Breathing Lying Down	O **Y** O **N**	Low Blood Pressure	O **Y** O **N**	Tumors/Growths
O **Y** O **N**	Epilepsy/Seizures	O **Y** O **N**	Mitral Valve Prolapse	O **Y** O **N**	Venereal Disease
O **Y** O **N**	Fainting/Dizziness				

Anything else not listed above? Please explain_____

10. Are you ***taking*** any of the following:

O **Yes** O **No**	Antibiotics or Sulfa Drugs	O **Yes** O **No**	Antihistamines	O **Yes** O **No**	Tranquilizers/Sleeping Aids
O **Y** O **N**	Anticoagulants (Blood Thinner)	O **Y** O **N**	Aspirin/Anti-inflammatory	O **Y** O **N**	Cortisone (Steroids)
O **Y** O **N**	Blood Pressure Medicine	O **Y** O **N**	Insulin/Diabetic Drugs	O **Y** O **N**	Herbs/Vitamins
O **Y** O **N**	Nitroglycerin	O **Y** O **N**	Non-Prescription Supplements		

Please list all supplements, over the counter medications, and prescription medications you are taking: _____

_____

11. Have you ever taken any bisphosphonates? (i.e. Boniva, Fosamax, Actonel, Atelvia, Reclast, etc)

If so, please list dates and frequency_____

12. Do you use any tobacco products? **Yes / No** How long?_____

13. Are you ***allergic*** to any of the following:

O **Yes** O **No** Local Anesthetic	O **Yes** O **No** Sulfa Drugs	O **Yes** O **No** Aspirin
O **Y** O **N** Penicillin/Amoxicillin	O **Y** O **N** Barbituates/sedatives	O **Y** O **N** LATEX
O **Y** O **N** Codeine		

Any other medications not listed above? Please list: _____

14. Women, Are you any of the following:

O **Yes** O **No** Pregnant/Trying to get pregnant?	O **Yes** O **No** Nursing?
O **Y** O **N** Taking Fertility Treatments?	O **Y** O **N** Taking oral contraceptives?

DENTAL HISTORY

1. What is the reason for your visit today?_____

2. Are you in good dental health? **Excellent** **Good** **Fair** **Poor**? Explain_____

3. When do you brush?_____Floss?_____

What kind of brush? **SOFT** **MEDIUM** **HARD** **ELECTRIC**

2. When was your last cleaning and exam?_____

3. Do you use nitrous oxide with dental treatment?.....**Yes / No**

4. Do you have a history of being difficult to anesthetize for dental treatment?.....**Yes / No**

5. Have you had any serious trouble associated with any previous dental treatment?.....**Yes / No**

If so, please explain_____

6. Do you have any fears about going to the dentist?.....**Yes / No**

If so, explain?_____

7. Are you wearing removable dental appliances?.....**Yes / No**

8. Do you have a history of gum disease or gingivitis?.....**Yes / No**

9. Do you currently have any of the following?

O **Yes** O **No** Bleeding, sore gums	O **Yes** O **No** Loose teeth	O **Yes** O **No** Shifting of teeth
O **Y** O **N** Unpleasant taste/bad breath	O **Y** O **N** Sensitive to hot	O **Y** O **N** Change in bite
O **Y** O **N** Burning tongue/lips	O **Y** O **N** Sensitive to cold	O **Y** O **N** Clicking/popping jaw
O **Y** O **N** Frequent blister lips/mouth	O **Y** O **N** Sensitive to sweets	O **Y** O **N** Difficult to open/close jaw
O **Y** O **N** Swelling/lumps in mouth	O **Y** O **N** Sensitive to biting	O **Y** O **N** Clenching/grinding
O **Y** O **N** Ortho treatment/braces	O **Y** O **N** Food impaction	O **Y** O **N** Headache/jaw muscle soreness in the morning
O **Y** O **N** Biting cheeks/lips		

Any other symptoms not listed above? Please explain: _____

10. Do you/have you been told you snore?.....**Yes / No**

11. Are you excessively tired during the day?.....**Yes / No**

12. Do you use a CPAP machine at night?.....**Yes / No**