

MEDICAL HISTORY

Patient Name: _____

D/O/B: _____

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

Are you currently under a physician's care? Yes No If yes, please explain: _____

Are you currently taking any medications, pills, or drugs? Yes No If yes, **please list:** _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other Medications containing bisphosphonates? Yes No If yes, please explain: _____

Do you use tobacco? Yes No If yes, please explain: _____

Do you use controlled substances? Yes No If yes, please explain: _____

Been told by a physician of a need to take **pre-medication** prior to having dental treatment provided? Yes No If yes, please explain: _____

WOMEN: (Please answer below)

Pregnant/ Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Please indicate (✓) if you have or previously have experienced an allergy to any of the following, explain reaction:

- | | | |
|---|--|--|
| <input type="checkbox"/> Acrylic _____ | <input type="checkbox"/> Food _____ | <input type="checkbox"/> Metal _____ |
| <input type="checkbox"/> Aspirin _____ | <input type="checkbox"/> Ibuprofen _____ | <input type="checkbox"/> Penicillin _____ |
| <input type="checkbox"/> Codeine _____ | <input type="checkbox"/> Latex _____ | <input type="checkbox"/> Sulfa Drugs _____ |
| <input type="checkbox"/> Erythromycin _____ | <input type="checkbox"/> Local Anesthetics _____ | <input type="checkbox"/> Other _____ |

Please indicate (✓) if you currently have or previously have been diagnosed or treated for any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack/Surgery | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Pace Maker/Stint | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Auto Immune Disorder | <input type="checkbox"/> Hepatitis: <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer/Type: _____ | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Leukemia | |
| <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Diabetes: <input type="radio"/> I <input type="radio"/> II | <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Multiple Sclerosis | |

Please list any serious medical condition or illness that may not be represented above: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be required, you have my permission to contact the respective health care provider/ agency who may release such information to you. I understand it is my responsibility to inform this office of any changes in my medical status and/ or any changes in any medications.

Patient/ Guardian Signature: _____ Date _____

Dentist/ Provider's Signature: _____ Date _____

Dr. Craig B. Lashley, D.D.S., P.A. Dr. Rebecca Twietmeyer, D.D.S.

(Please complete other side)

DENTAL HISTORY

What is the reason for your visit today? _____

Do you currently have any dental concerns? Yes No If yes, please describe _____

Name of Previous Dental Provider _____ Tel # () _____

Address _____

Date of Last Dental Exam _____ Date of Last Dental Cleaning _____ Date of Last X-rays _____

How often do you have dental examination? 4 months 6 months Annually Other, _____

How frequently do you brush? Daily 2 times daily Other How frequently do you floss? Daily Weekly Other

Is there anything about the appearance of your teeth that you are unhappy with or would like to change? Yes No

If yes, please describe: _____

Do you ever feel nervous about your visits at the dental office? Yes No If yes, please describe: _____

Have you ever had an upsetting dental experience in the past? Yes No

Do you have any special requests or anything else that we should know about your dental experiences that would make you time spent with us easier? Yes No
(Likes or Dislikes) _____

Please indicate (✓) if you currently have or previously have experienced any of the following:

Have teeth that are sensitive to any of the following:

Hot Cold Sweets Biting Chewing

Notice any mouth odors or bad tastes? Yes No

Experience cold sores, blisters or any other oral lesion? Yes No

Experience your gums bleeding or any related discomfort with gum tissues? Yes No

Experience any loose teeth or a change in your bite relationship? Yes No

Experience food catching between teeth? Yes No

Do You:

Clench or grind your teeth while awake or while sleeping? Yes No

Bite lips or cheeks regularly? Yes No

Hold foreign objects with teeth? (pens, nails, etc.) Yes No

Breathe through mouth while awake or while sleeping? Yes No

Feel jaw is tired, especially after waking from sleeping? Yes No

Snore or have any other sleeping disorders? Yes No

Smoke or use any other tobacco products? Yes No

Experience any clicking or popping of the jaw? Yes No

Experience any pain in the jaw, ear or side of face? Yes No

Experience any difficulty in opening or closing mouth? Yes No

Experience any difficulty chewing on either side of mouth? Yes No

Experience any headaches, neck aches or shoulder aches? Yes No

Please indicate (✓) if you have had any of the following:

Orthodontic Treatment

Periodontal Treatment

Oral Surgery

TMJ Treatment

Experience serious injury to mouth or head

Thank you for filling out this form completely. It will enable us to help you more effectively.

If you have any questions at any time, please ask. We are happy to help.

Welcome to our office!