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**:_____

_____

Preferred Pharmacy (Name and Number):_____

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:

☐ Acrylic _____	☐ Food _____	☐ Metal _____
☐ Aspirin _____	☐ Ibuprofen _____	☐ Penicillin _____
☐ Codeine _____	☐ Latex _____	☐ Sulfa Drugs _____
☐ Erythromycin _____	☐ Local Anesthetics _____	☐ Other _____

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

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

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!

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.