

MEDICAL and DENTAL HISTORY



MEDICAL

Have you ever had any of the following? Please check all those that apply:

- | | | | |
|---|--|--|---|
| <input type="radio"/> ADD/ADHD | <input type="radio"/> Diabetes <u>I or II?</u> | <input type="radio"/> High or Low Blood Pressure | <input type="radio"/> Recreational Drug Use |
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Digestive Problems | <input type="radio"/> Jaundice | <input type="radio"/> Respiratory Problems |
| <input type="radio"/> Allergies | <input type="radio"/> Dizziness | <input type="radio"/> Kidney Disease | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Artificial Joints | <input type="radio"/> Epilepsy | <input type="radio"/> Liver Disease | <input type="radio"/> Seizures |
| <input type="radio"/> Asthma | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Mental Disorders | <input type="radio"/> Steroids |
| <input type="radio"/> Autism | <input type="radio"/> Fainting | <input type="radio"/> Nervous Disorders | <input type="radio"/> Stroke |
| <input type="radio"/> Blood Thinner | <input type="radio"/> Head Injury | <input type="radio"/> Pacemaker | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Blood Disease | <input type="radio"/> Heart Disease | <input type="radio"/> Panic Attacks | <input type="radio"/> Tumors/Growths |
| <input type="radio"/> Breast Feeding | <input type="radio"/> Heart Murmur | <input type="radio"/> Pregnant—Due Date _____ | <input type="radio"/> Ulcers |
| <input type="radio"/> Cancer | <input type="radio"/> Hepatitis <u>A, B, or C?</u> | <input type="radio"/> Radiation Treatment | <input type="radio"/> Venereal Disease |

Allergic to Penicillin Latex Other: _____

Please check yes or no to the following, if yes, please explain:

Name of Physician and Phone #: _____

Yes No Are you now under care of a Physician?

Yes No Are you taking any medications? If yes, please list:

Yes No Have you ever taken the diet drugs Redux, Phen-Phen or Pondimin?

Yes No Have you ever been hospitalized for surgery or serious illness? Please explain:

Yes No Do you have any health problems that need further clarification? Please explain:

DENTAL

How often do you go to the dentist? _____

When and what was achieved at your last dental visit? _____

Please list any questions you have regarding your mouth or oral health and your reason for this visit:

Please check yes or no to the following, if yes, please explain:

Yes No Have you ever had local anesthetic?

Yes No Have you ever had an unfavorable reaction from a local anesthetic?

Yes No Have you ever had orthodontic treatment (braces)?

Yes No Do you smoke or chew tobacco products? How long and how often?

Yes No Have you ever been treated for periodontal (gum) disease?

Yes No Do you feel nervous about having dental treatment?

Yes No Do you have sensitive teeth?

Yes No Do you experience dry mouth?

Yes No Do you have food that traps uncomfortably in a specific spot in your mouth?

Yes No Do you grind or clench your teeth? Time of day this occurs?

Yes No Are you happy with the color, shape, size and spacing of your teeth? If NO, what are your specific concerns?

How many times a day do you brush your teeth? _____ How often do you floss? _____

What type of toothbrush do you use? _____ Soft _____ Medium _____ Hard _____ Electric

What other cleaning aids, devices or rinses do you use? _____

I hereby authorize Dr. Tammy Weyandt/Dr. Anna Willison to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have changes in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian if under 18

Relationship to the patient

Date