

Stephanie R. White D.M.D.

Gearhart Dentistry

3965 Hwy 101 N.

Gearhart OR 97138

(503)738-9273

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DENTAL AND MEDICAL HISTORY

Patient Name:

Last

First

MI

Preferred Name

What is the reason for your visit today?

- ☐ Checkup/Cleaning ☐ Implant Evaluation ☐ Denture Evaluation ☐ Tooth Ache
☐ Other

If other, please describe

Date of Last Cleaning

- ☐ 4-6 months ago ☐ 6-12 months ago ☐ 12-24 months ago
☐ more than 2 years ago

Previous Dentist's name, Address, Phone Number

How often do you brush your teeth?

- ☐ Once a day ☐ Twice a day ☐ More than twice a day

How often do you floss?

- ☐ Never ☐ Occasionally (1-3 times per week)
☐ Frequently (more than 4 times per week)

What other dental aids do you use?

- | | | |
|--|--|--|
| <input type="checkbox"/> Sonicare Toothbrush | <input type="checkbox"/> Electric Toothbrush | <input type="checkbox"/> Manual Toothbrush |
| <input type="checkbox"/> Toothpicks | <input type="checkbox"/> Interplak | <input type="checkbox"/> Proxybrush |
| <input type="checkbox"/> Rubbertip | <input type="checkbox"/> Waterpik | <input type="checkbox"/> Rotopoints |

Do you have any dental problems now?

- ☐ Yes ☐ No

If yes, please describe:

Do You: Please check all that apply

- ☐ Notice any mouth odors or bad tastes?
- ☐ Frequently get cold sores, blisters, or any other oral lesions?
- ☐ Gums bleed or hurt?
- ☐ Clench or grind your teeth while awake or asleep?
- ☐ Bite your lips or cheeks regularly?
- ☐ Hold foreign objects with your teeth?
- ☐ Mouth breathe while awake or asleep?
- ☐ Have soreness, stiffness or pain in the muscles of head or neck?
- ☐ Have problems with "Dry Mouth"
- ☐ Have tired jaws, especially in the morning?
- ☐ Snore or have any other sleeping disorders?
- ☐ Smoke/chew tobacco or use tobacco products?
- ☐ Have you or your parents experienced gum disease or tooth loss?
- ☐ Have you noticed any loose teeth or change in your bite?

Does food get caught between your teeth?

- ☐ Yes ☐ No

Have you ever had: Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Orthodontic treatment (braces)? | <input type="checkbox"/> Periodontal treatment (gum disease)? |
| <input type="checkbox"/> A bite plate or mouth guard? | <input type="checkbox"/> Oral Surgery (extractions)? |
| <input type="checkbox"/> Your teeth ground or the bite adjusted? | <input type="checkbox"/> A serious injury to the mouth or head? |

Have you experienced: Check all that apply:

- ☐ Clicking or popping of the jaw?
- ☐ Difficulty in opening or closing your mouth?
- ☐ Headaches, neckaches or shoulder aches?
- ☐ Pain (joint, ear, side of face)?
- ☐ Difficulty in chewing on either side of the mouth?
- ☐ Problems or complications with previous dental treatment?

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Are you satisfied with your teeth's appearance?

☐ Yes ☐ No

Would you like to keep all of your teeth all of your life?

☐ Yes ☐ No

Do you feel nervous about having dental treatment?

☐ Yes ☐ No

If yes, what is your biggest concern?

Have you ever been told to take a pre-medication (antibiotic) prior to dental treatment?

☐ Yes ☐ No

If yes, for what reason?

MEDICAL HISTORY

Physician's Name, Address and Phone Number:

Have you had any medical care or surgeries in the past two years? If yes, please describe:

Have you taken any prescription or non-prescription drugs in the past 2 years?

☐ Yes ☐ No

Are you currently taking any medications, drugs, pills or herbal remedies, including regular dosages of aspirin?

☐ Yes ☐ No

If yes, please list names and dosage.

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?

☐ Yes ☐ No

Have you noticed any sensitivity to metals in jewelry or dental materials?

☐ Yes ☐ No

Are you aware of having an allergic (or adverse) reaction to any substance or medication?

☐ Yes ☐ No

If yes, please specify:

Have you lost or gained more than 10 pounds in the past year?

☐ Yes ☐ No

Have you been a patient in the hospital during the past five years?

☐ Yes ☐ No

If yes, please describe:

Do you have or have you had any disease, condition, or problem not listed?

☐ Yes ☐ No

If yes, please list:

Is there anything else you would like us to know about you before your dental visit?

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT. CHECK ALL THAT APPLY.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> *PRE MED | <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Allergies/Seasonal | <input type="checkbox"/> Allergy-Codeine |
| <input type="checkbox"/> Allergy-Drug | <input type="checkbox"/> Allergy-Food | <input type="checkbox"/> Allergy-Latex | <input type="checkbox"/> Allergy-Penicillin |
| <input type="checkbox"/> Allergy-Sulfa | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Heart Valve |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer/Chemo | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diet-Special/Restrict | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Drug Abuse/Dependence | <input type="checkbox"/> Emphysema |

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- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever/Hives | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hemophilla |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hepitatis B | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> IBS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mitral Valve Prolaps | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Neurological Disorde | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Psychiartic Care | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors/Cancer | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | |

Women:

Are you pregnant or think you could be pregnant?

☐ Yes ☐ No

Are you nursing?

☐ Yes ☐ No

do you use birth control prescriptions?

☐ Yes ☐ No

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 needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: _____

Date:

☐ By checking this box, I acknowledge that I have read this statement and agree to the contents.

History Review (for office use only)

Response Date: