METROPARK DENTAL ARTS

MEDICAL AND DENTAL HISTORY (to be completed by patient)

Patient's Full Name:_____ Date of Birth:_____mm/dd/yy_____ ❒ Male ❒ Female

Patient's ❒ Current ❒ Previous Dentist(s):_____ Date of Last Dental Cleaning:_____mm/dd/yy_____

Patient's ❒ Current ❒ Previous Physician(s):_____ Date of Last Physical Exam: _____mm/dd/yy_____

A Please list your chief concerns for treatment: (# in order of priority):_____

_____

_____

B What or who motivated you to seek treatment and what do you expect?_____

C List all current medications including non-prescriptions:_____

_____

_____

D List all drug allergies:_____

_____

E List previous surgeries:_____

_____

Please describe all "Yes" answer (use space at bottom of page if necessary)

MEDICAL	YES	NO
1 High Blood Pressure _____	❒	❒
2 Chest pains or heart attack _____	❒	❒
3 Stroke _____	❒	❒
4 Rheumatic Fever/Mitral Valve Prolapse _____	❒	❒
5 Any heart trouble, murmur or mitral valve prolapse, Angina____	❒	❒
6 Prosthetic devices (heart, valve, hip, knee, etc.) _____	❒	❒
7 Any lung disease (T.B., emphysema, etc.) _____	❒	❒
8 Asthma_____	❒	❒
9 Allergies or hay fever _____	❒	❒
10 Sinus problems _____	❒	❒
11 Mouth breathing or excessive snoring _____	❒	❒
12 Ulcers or stomach problems _____	❒	❒
13 Diabetes_____	❒	❒
14 Hepatitis or liver disease (Jaundice)_____	❒	❒
15 Kidney or bladder disease _____	❒	❒
16 Thyroid trouble _____	❒	❒
17 Connective tissue disease _____	❒	❒
18 Arthritis or rheumatism _____	❒	❒
19 Cancer (type, date) _____	❒	❒
20 Serious illness not listed (list type, date) _____	❒	❒
21 Subject to prolonged bleeding or bruise easily _____	❒	❒
22 Glaucoma _____	❒	❒
23 Epilepsy, convulsions or seizures _____	❒	❒
24 Do you have HIV (AIDS)? _____	❒	❒
25 Are you taking any Bisphosphonates (Fosamax, Aredia, Didronel) _	❒	❒
26 Pregnant or possibly pregnant (Nursing)_____	❒	❒
27 Using birth control medications _____	❒	❒
28 Use tobacco (types/how much) _____	❒	❒

DENTAL	YES	NO
29 Pain, popping, catching or locking in jaw joints _____	❒	❒
30 Clench or grind your teeth _____	❒	❒
31 Wake up with sore jaws _____	❒	❒
32 Frequent headaches (How many per week?____) _____	❒	❒
33 Dizziness, ringing or pain in ears _____	❒	❒
34 Tenderness or stiffness in the jaw, neck or back _____	❒	❒
35 History of TMJ (jaw joint) problems or therapy _____	❒	❒
36 Have you ever received instructions regarding care of your teeth or gums __	❒	❒
37 Treated for or told you have gum disease _____	❒	❒
38 Treated or consulted for orthodontic therapy _____	❒	❒
39 Had head, neck or jaw injuries _____	❒	❒
40 Dental x-rays taken in the last year _____	❒	❒
41 Brush your teeth (how often) _____	❒	❒
42 Floss your teeth (how often) _____	❒	❒
43 Bad breath or unpleasant tastes in your mouth _____	❒	❒
44 Bleeding gums _____	❒	❒
45 Sore or painful teeth_____	❒	❒
46 Tooth sensitivity (hot, cold, sweets) _____	❒	❒
47 Fever blisters or mouth ulcers _____	❒	❒
48 Tongue thrusting habit _____	❒	❒
49 Place a high priority on keeping your natural teeth _____	❒	❒
50 Do you like your smile _____	❒	❒

Please expand on the above information (refer to letter or number) or add anything you feel is important: _____

_____

_____

_____

_____

The above information is accurate and complete to the best of my knowledge:

Date: _mm/dd/yy_ **Patient or Guardian's Signature:** _____ **Doctor's Signature:** _____

Updated:_mm/dd/yy_ P or G's Initials: _____ ,_mm/dd/yy_; _____, _mm/dd/yy_; _____, _mm/dd/yy_; _____, _mm/dd/yy_;_____;