St. Croix Falls General Dentistry

MEDICAL HISTORY

PATIENT NAME _____

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

Are you under a physician's care now? ◯ Yes ◯ No ◯ N/A _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ◯ N/A _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ◯ N/A _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No ◯ N/A _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ◯ N/A

Do you use tobacco? ◯ Yes ◯ No ◯ N/A

Are you on a special diet? ◯ Yes ◯ No ◯ N/A

Do you use controlled substances? ◯ Yes ◯ No ◯ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ◯ N/A _____

Comments: _____

_____

_____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

MEDICAL/DENTAL HEALTH UPDATE - Please verify changes in your health status at regular intervals

Date	Change In Health Status?	Signature	Date	Change In Health Status?	Signature
_____	☐ Yes ☐ No	_____	_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____	_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____	_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____	_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____	_____	☐ Yes ☐ No	_____

Continued from front side

14. Medications being taken now - Please list:

_____

_____

_____

_____

_____

Yes	No	15. Women
☐	☐	a. Are you taking contraceptives?
☐	☐	b. Are you pregnant?
☐	☐	c. Have you had a miscarriage or stillbirth?
☐	☐	d. Have you had a baby with birth weight more than 10 pounds, or low weight?
☐	☐	e. Are you nursing presently?

DENTAL INFORMATION

Yes	No	
☐	☐	16. Have you ever had an upsetting experience in the dental office?
☐	☐	17. Is it important for you to keep your teeth?
☐	☐	18. Are you dissatisfied with the appearance of your teeth?
☐	☐	19. Are you dissatisfied with the function of your teeth?
☐	☐	20. Is there anything about having dental treatment that bothers you?
☐	☐	21. Does food tend to become caught between your teeth?
☐	☐	22. Do your gums often bleed while brushing?
☐	☐	23. Have you noticed any loosening of teeth?
☐	☐	24. Have you had an injury to your head, neck, or jaw?
		25. Habits - Do you:
☐	☐	a. Clench your teeth while awake or asleep?
☐	☐	b. Bite your lips or cheek frequently?
		26. Problems of the jaw - Have you noticed:
☐	☐	a. clicking of the jaw?
☐	☐	b. Pain (joint, ear, side of face)?
☐	☐	c. Difficulty in opening or closing?
☐	☐	d. Difficulty in chewing?
		27. Have you had:
☐	☐	a. Orthodontic treatment (braces)?
☐	☐	b. Oral surgery?
☐	☐	c. Gum treatment?
☐	☐	d. Your bite adjusted?
☐	☐	e. Worn a bite plane or other appliance?
☐	☐	28. Are you having dental pain at this time?
☐	☐	29. Has any one in your family had gum treatment?
☐	☐	30. Do you supplement your diet with fluoride?

31. Date of last dental treatment _____

32. Date of last teeth cleaning _____

Please explain if you answered "YES" to, or are uncertain about, any of the above items.

_____

_____

_____

_____

_____

To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature - Patient (or parent/guardian if patient is under age 18) Date