Medora Dental Care

MEDICAL HISTORY

Name and phone number of your family physician: _____
Most recent physical examination:_____Purpose: _____
How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you ever had:	**YES**	**NO**
1. Have you ever had a serious illness, or surgery that requires you to take pre-medication prior to dental procedures? Please explain: _____	☐	☐
2. Hospitalization for an illness or injury? _____	☐	☐

3. An allergic reaction to:

☐ Aspirin, Ibuprophen, Acetaminophen, Codeine Penicillin
☐ Tetracycline ☐ Erythromycin Sulfonamide (Sulfa)
☐ Iodine ☐ Latex
☐ Local anesthetic ☐ Fluoride
☐ Acrylics ☐ Metals (nickel, gold, silver,_____)
☐ Other: _____

4. Have you had/have any of the following diseases or conditions? ☐ ☐

☐ Digestive disorder ☐ Stomach conditions, ulcers, hyperacidity or acid reflux
☐ Jaundice ☐ Liver disease
☐ Kidney disease ☐ Thyroid disease
☐ Diabetes ☐ Glaucoma
☐ High blood pressure ☐ Low blood pressure
☐ Tuberculosis ☐ Asthma
☐ Venereal disease ☐ Hay fever, hives or skin rash
☐ Arthritis or joint conditions ☐ Allergies
☐ HIV/AIDS ☐ Hepatitis (Type A / B / C / D)
☐ Artificial heart valve ☐ Pacemaker or implantable defibrillator
☐ Heart conditions ☐ Stroke
☐ Tendency to faint ☐ Prolonged bleeding
☐ Anemia or other blood disorders
☐ Epilepsy, seizures or neurological conditions
☐ Cancer, tumor, radiation treatment or chemotherapy
☐ Mental health disturbances or depression
☐ Autism, Asperger's or sensory interruption disorder
☐ Speech disorder/speech therapy
☐ Eating disorder (anorexia/bulimia)
☐ Tonsil or adenoid conditions
☐ Vision or hearing conditions
☐ Artificial prosthesis (heart valve or joints)

5.	Has any member of your immediate family had diabetes?	☐	☐
6.	Do you have difficulty breathing through your nose?	☐	☐
7.	Do you have mouth breathing habits or snore at night?	☐	☐
8.	Do you have frequent, severe headaches?	☐	☐
9.	Do you have any dental implants?	☐	☐
10.	Do you smoke or use tobacco products?	☐	☐
11.	WOMEN ONLY ---		
	Are you pregnant? If so which month? _____	☐	☐
	Are you planning a pregnancy in the near future?	☐	☐
	Is there a chance you may be pregnant?	☐	☐
	Are you on birth control?	☐	☐

12. Do you have any disease or condition that is not listed above?
If yes, please explain:
_____
_____

13. Are you currently undergoing any medical treatment right now?
If yes, please explain:
_____
_____

Do you currently take any medication, supplements and or vitamins regularly? ☐ **YES** ☐ **NO**
If yes please list them as well as their purpose and dosage.

	Drug	Purpose	Dosage
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Date of most recent dental examination: ___/___/___
Purpose: _____
Date of most recent dental x-rays: ___/___/___
Date of most recent dental treatment (other than a cleaning): ___/___/___
I routinely see my dentist every: ☐ 3mo ☐ 4mo ☐ 6mo ☐ 12mo ☐ Not routinely

What is your immediate concern? _____

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Please answer yes or no to the following questions: **YES** **NO**

Personal History:

1. Are you fearful of the dentist? If yes on a scale of 1-10(very) ____ ☐ ☐
2. Have you had an unfavorable dental experience? ☐ ☐
3. Have you had complications with past dental treatment? ☐ ☐
4. Have you ever had trouble with freezing or a reaction to local anesthetic? ☐ ☐
5. Have you ever had braces or orthodontic treatment in the past? ☐ ☐
6. Do you have any oral habits such as clenching, grinding your teeth or nail biting? ☐ ☐
7. Do you have any habits such as finger or thumb sucking? ☐ ☐
8. Have you ever had instruction with using a toothbrush and floss? ☐ ☐

Smile Characteristics:

9. Is there anything about the appearance of your smile you would like to change? ☐ ☐
10. Are you self conscious about your teeth? ☐ ☐
11. Have you ever whitened your teeth? ☐ ☐
12. Are you interested in whitening your teeth? ☐ ☐
13. Are you interested in aligning your teeth? ☐ ☐
14. Have you been disappointed with the appearance of previous dental work? ☐ ☐

Bite and Joint:

15. Do you/would you have trouble chewing gum? ☐ ☐
16. Do you/would you have trouble chewing nuts or other hard foods? ☐ ☐
17. In the past 5 years have your teeth become shorter, thinner or worn? ☐ ☐
18. Are your teeth starting to become crowded or developing spaces? ☐ ☐
19. Do you ever wake up with pain or soreness in your jaw or face muscles? ☐ ☐
20. Do your jaw joints click, pop, lock or have limited opening? ☐ ☐
21. Do you have tension headaches or sore teeth? ☐ ☐
22. Have you ever had trauma/injury to your head, face or neck? ☐ ☐
23. Do you or have you ever worn a bite appliance/night guard? ☐ ☐

Tooth Structure

24. Have you had any cavities in the past 3 years? ☐ ☐
25. Do you have a dry mouth? ☐ ☐
26. Are any of your teeth sensitive to hot, cold, biting, or sweets? ☐ ☐
27. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? ☐ ☐
28. Do you avoid brushing any part of your mouth? ☐ ☐
29. Do you feel or notice any holes/pitting in your teeth? ☐ ☐

Gum and Bone

30. Have you ever been diagnosed or treated for periodontal (gum) disease? ☐ ☐
31. Have you ever experienced gum recession? ☐ ☐
32. Is there anyone with a history of periodontal disease in your family? ☐ ☐
33. Do your gums bleed when brushing, flossing or eating? ☐ ☐
34. Are any of your teeth becoming mobile? ☐ ☐
35. Have you ever noticed an unpleasant taste or odor coming from your mouth? ☐ ☐
36. Do you have or experience cold sores or frequent canker sores? ☐ ☐

Patient name: _____ Date of Birth: _____

Signature of Patient, parent/guardian:_____

Date:_____

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