ROCHESTER
DENTAL CLINIC
Patient focused, Family Friendly

Medical History

Patient Name ______________________ Nickname ______________________ Age______

Name of Physician/ and their specialty ______________________________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

Antibiotic PRE-MED: Do you require antibiotics prior to dental treatment? ☐Yes ☐No

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury______	☐	☐
2. an allergic reaction to ☐aspirin, ibuprofen, acetaminophen, codeine ☐penicillin ☐other antibiotics ______ ☐local anesthetic ☐metals (nickel, gold, silver) ☐latex ☐other ______		
3. heart problems, or cardiac stent within the last 6 months _	☐	☐
4. history of infective endocarditus ______	☐	☐
5 artificial heart valve, repaired heart defect ______	☐	☐
6. pacemaker or implantable defibrillator ______	☐	☐
7. artificial prosthesis (heart valve or joints) ______	☐	☐
8. high or low blood pressure ______	☐	☐
9. a stroke ______	☐	☐
10. anemia or other blood disorder ______	☐	☐
11. prolonged bleeding due to a slight cut (INR >3.5) ______	☐	☐
12. Coumadin / Warfarin Use ______	☐	☐
13. tuberculosis ______	☐	☐
14. asthma ______	☐	☐
15. breathing or sleep problems (i.e. snoring, sinus) ______	☐	☐
16. kidney disease ______	☐	☐
17. liver disease ______	☐	☐
18. thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
19. diabetes ______	☐	☐
20. digestive disorders (i.e. heartburn or gastric reflux) ______	☐	☐

	YES	NO
21. osteoporosis / osteopenia______	☐	☐
22. history of bisphoiphonate use (Actonel*, Boniva*, Fosamax*, Aredia*, Zometa*, etc.) ______	☐	☐
23. arthritis ______	☐	☐
24. glaucoma______	☐	☐
25. head or neck injuries ______	☐	☐
26. epilepsy, convulsions ______	☐	☐
27. viral infections and cold sores ______	☐	☐
28. any lumps or swelling in the mouth ______	☐	☐
29. hepatitis (type_____) ______	☐	☐
30. HIV / AIDS ______	☐	☐
31. tumor / abnormal growth ______	☐	☐
32. radiation therapy ______	☐	☐
33. chemotherapy ______	☐	☐
34. psychiatric treatment ______	☐	☐
35. antidepressant medication ______	☐	☐
36. alcohol abuse / addiction ______	☐	☐
37. street drug abuse / addiction ______	☐	☐
ARE YOU:		
38. presently being treated for any other illness______	☐	☐
39. aware of a change in your health (i.e. fever, new cough)__	☐	☐
40. often exhausted or fatigued ______	☐	☐
41. experiencing frequent headaches ______	☐	☐
42. a smoker, smoked previously or use smokeless tobacco _	☐	☐
43. often unhappy or depressed ______	☐	☐
44. FEMALE - pregnant / nursing ______	☐	☐

Descibe any medical treatment, impending surgery, genetic / developmental anomalies, or other medical concerns that may possibly affect your dental treatment.

____

List all current medication and dosages. (Including aspirin, birth control pills, vitamins, herbal suppliments, blood thinners, etc.)

Drug	Dose	Drug	Dose

Ask for additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ______________

Doctor's Signature ______________________________ Date ______________

DENTAL HISTORY

Previous Dentist ______________________________
Date of most recent dental exam _____/ ______/ ______ Date of most recent x-rays _____/ ______/ ______
Date of most recent treatment (other than cleaning) _____/ ______/ ______
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6mo. ☐ 12mo. ☐ Not routinely

What is your immediate concern? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful on a scale of 1(least) to 10(most) ______	☐	☐
2. Have you had an unfavorable dental experience?______	☐	☐
3. Have you ever had complications from past dental treatment?______	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?______	☐	☐
5. Did you ever have braces, orthodontic treatment or have your bite adjusted?______	☐	☐
6. Have you had any teeth removed?______	☐	☐
Smile Characteristics		
7. Is there anything about the appearance of your teeth that you would like to change?______	☐	☐
8. Have you ever whitened (bleached) your teeth?______	☐	☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth?______	☐	☐
10. Have you been disappointed with the appearance of your previous dental work?______	☐	☐
Bite and Jaw Joint		
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking)______	☐	☐
12. Do you / would you have problems chewing bagels, hard foods, or gum?______	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?______	☐	☐
14. Are your teeth crowding or developing spaces?______	☐	☐
15. Do you have more than one bite and squeeze to make your teeth fit together?______	☐	☐
16. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?______	☐	☐
17. Do you clench your teeth in the daytime or make them sore?______	☐	☐
18. Do you have any problems sleeping or wake up with an awareness of your teeth?______	☐	☐
19. Do you wear or have you ever worn a bite appliance (night guard)?______	☐	☐
Tooth Structure		
20. Have you had any cavities within the past 3 years?______	☐	☐
21. Do you have a dry mouth or difficulty swallowing food?______	☐	☐
22. Are any teeth sensitive to hot, cold, biting or sweets?______	☐	☐
23. Have you ever broken teeth, chipped teeth. or had a toothache or cracked filling?______	☐	☐
24. Do you frequently get food caught between any teeth?______	☐	☐
Gum and Bone		
25. Do your gums bleed or are they painful when brushing any part of your mouth or flossing ?______	☐	☐
26. Have you ever been treated for gum disease or been told you have lost bone around your teeth?______	☐	☐
27. Have you ever noticed an unpleasant taste or odor in your mouth?______	☐	☐
28. Is there anyone with a history of periodontal desease in your family?______	☐	☐
29. Have you experienced gum recession?______	☐	☐
30. Have you had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
31. Have you experienced a burning senastion in your mouth?______	☐	☐

Patient's Signature ____ Date ________________

Doctor's Signature ____ Date ________________