TOWN SQUARE DENTAL CARE

Today's Date: _____

Adult Dental and Medical Health History Form

PATIENT INFORMATION

First Name: Last Name: Middle Name:

Home Phone: Cell Phone: Work Phone:

Email Address:

Mailing Address: City: State: Zip:

Date of Birth: / / Gender:

Occupation:

Emergency Contact: Name: Relationship: Phone:

If you are completing this form for another person, what is your name and relationship to the person:

Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

Are you currently experiencing any dental pain or discomfort? ☐Yes ☐No If yes, Where?

When was your last Dental Exam? / / Last time you had dental x-rays taken?

Please check any box that applies to you:

Is it hard to open your mouth?..... ☐

Does it hurt to chew, bite or swallow?..... ☐

Do your gums bleed when you brush or floss your teeth?..... ☐

Have you ever had periodontal (gum) treatments like scaling and root planing?..... ☐

Do you have, or have you ever had, any sores or growths in your mouth?..... ☐

Do you clench or grind your teeth?..... ☐

Does your jaw click, pop or hurt?..... ☐

Do you have earaches or neck pains?..... ☐

Does dental treatment make you nervous?..... ☐

Have you ever experienced any of these sleep-related disorders?

☐Mouth Breathing ☐Snoring

☐Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth?..... ☐

If yes, please describe what happened and when it happened:

_____

_____

Have you ever had problems with dental treatment in the past?..... ☐

If yes, please describe what happened: _____

_____

Have you ever had a reaction to dental anesthesia?..... ☐

If yes, please describe what happened: _____

_____

Are you unhappy with your smile?..... ☐

If yes, why? Please mark all that apply:

☐Color of your teeth ☐Shape of your teeth

☐Position of your teeth

☐Other: _____

MEDICATION & OTHER PRODUCTS/SUBSTANCES

Please check the box to mark your answers to the following questions: Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto), dabigatran (Pradaxa), clopidogrel (Plavix) heparin or aspirin)?..... ☐ ☐ ☐

If yes, what medication are you taking? _____

Last known INR: _____ Date of last INR: _____/_____/_____

Are you taking any medication to treat **osteoporosis** or Paget's disease?..... ☐ ☐ ☐

Some commonly-prescribed drugs include alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva), Zolendronate (Reclast), and denosumab (Prolina)

If yes, what medication are you taking? _____

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

..... ☐ ☐ ☐

Some commonly-prescribed drugs included denosumab (Xgeva), pamidronate (Aredia) or zolendronate (Zometa).

If yes, what medication are you taking? _____ How many years have you been taking it? _____

Are you taking **hormonal replacements?**..... ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)?..... ☐ ☐ ☐

Do you use **vaping products**?

..... ☐ ☐ ☐

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons?

..... ☐ ☐ ☐

If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐Several times per week ☐Weekly ☐ Occasionally

Was the substance prescribed by a doctor? ☐Yes ☐No If yes, for what reasons(s)? _____

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?**.....☐ ☐ ☐
If yes, please list them on the back of the form in the "MEDICATION" box.

Women only: Are you:

Taking **birth control pills?**

.....☐ ☐ ☐

Pregnant? ☐Yes ☐No If yes, number of weeks: _____ **Nursing?** ☐Yes ☐ No

ALLERGIES (examples: Latex, Penicillin/Amoxicillin, Sulfa).....☐Yes ☐No

If yes, do you carry an epi pen: ☐ Yes ☐ No

Please list Allergies: _____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / / What is your normal blood pressure (systolic, diastolic)?

Doctor's name: Phone:

Please check any box that applies to you:	Yes	No	?
Are you in good physical health?.....	☐	☐	☐
Are you currently being seen or treated by a physician?.....	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?.....	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?.....	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger,ect)?.....	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?.....	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?.....	☐	☐	☐

If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC Please check the box that applies to you:

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/Implanted defibrillator.....	☐	☐	☐
Artificial (prosthetic) heart valve.....	☐	☐	☐
Previous infective endocarditis.....	☐	☐	☐
Congenital heart disease (CHD).....	☐	☐	☐
Unrepaired, cyanotic CHD.....	☐	☐	☐
Repaired (completely) in the last 6 mo...	☐	☐	☐
Repaired CHD with residual defects.....	☐	☐	☐
Arteriosclerosis.....	☐	☐	☐
Coronary artery disease.....	☐	☐	☐
Congestive heart failure.....	☐	☐	☐
Damaged heart valves.....	☐	☐	☐
Heart attack.....	☐	☐	☐
Heart murmur/rhythm disorder.....	☐	☐	☐

	Yes	No	?
Cancer.....	☐	☐	☐
Type: _____			
Date of Diagnosis: _____			
Chemotherapy: _____			
Radiation Treatment: _____			
Blood (Circulatory) Health			
Anemia.....	☐	☐	☐
Blood transfusion.....	☐	☐	☐
If yes, date: _____			
Hemophilia.....	☐	☐	☐
High or low blood pressure.....	☐	☐	
Brain (Neurological)/Mental Health			

	Yes	No	?
Digestive Health			
Gastrointestinal disease.....	☐	☐	☐
G.E. reflux/persistent heartburn (GERD).....	☐	☐	☐
Stomach ulcers.....	☐	☐	☐
Other			
Arthritis.....	☐	☐	☐
Chronic pain.....	☐	☐	
Diabetes (type I or II).....	☐	☐	☐
Last known A1C:_____			
Date of last A1C:_____			
Eating Disorder.....	☐	☐	
Frequent infections.....	☐	☐	☐
Type of infections: _____			
Hepatitis, jaundice, or liver disease.....	☐	☐	☐
Immune deficiency.....	☐	☐	☐

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Rheumatic heart disease…… ☐ ☐ ☐

Stroke…… …… ☐ ☐ ☐

Anxiety…… …… ☐ ☐ ☐

Depression…… .. ☐ ☐ ☐

Epilepsy/seizures…….. ☐ ☐ ☐

Date of last seizures: _____

Kidney problems…… ☐ ☐ ☐

Malnutrition…… ….. ☐ ☐☐

Osteoporosis…… …. ☐ ☐ ☐

Yes No ?

Mental health disorders…….. ☐ ☐ ☐

Neurological disorders……..☐ ☐ ☐

Post-traumatic stress disorder…… ☐ ☐ ☐

Traumatic brain injury or concussion ☐ ☐ ☐

Rheumatoid arthritis…….. .☐ ☐ ☐

Sexually transmitted infection (STI)…… ☐ ☐ ☐

Thyroid Problem…… ☐ ☐ ☐

Substance abuse……... ☐ ☐ ☐

Breathing (Respiratory) Health

Asthma (COPD)…… ☐ ☐ ☐

Date of last asthma attack: _____

Do you carry a rescue inhaler? ☐ Yes ☐ No

Ever Hospitalized? ☐ Yes ☐ No

If yes, date: _____

Bronchitis…… ….. ☐ ☐ ☐

Emphysema…….... .. ☐ ☐ ☐

Sinus trouble…….. ☐ ☐ ☐

Tuberculosis …… ☐ ☐ ☐

Autoimmune Disease

AIDS or HIV infection…… ☐ ☐ ☐

Lupus…… ….. ☐ ☐ ☐

Eye (Vision) Health

Glaucoma…… …. ☐ ☐ ☐

Surgeries:

Type of surgery: _____

Date of surgery: _____

Type of surgery: _____

Date of surgery: _____

Do you have any disease, condition, or problem that's not listed here? If so, please explain: _____

MEDICATIONS

Please List any medications, vitamins, or herbal supplements: _____

_____

_____

NOTE: **It's important for both the doctor and the patient to talk honestly about the patient's health before dental treatment starts.**

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____

How did you hear about us?

☐ Google/Website ☐ Social Media ☐ Newspaper ☐ Radio ☐ Patient Referral