Whitaker
FAMILY DENTISTRY

PATIENT MEDICAL HISTORY

TO NEW PATIENTS: IT'S NICE TO GET ACQUAINTED.
TO OUR EXISTING PATIENT FAMILY: WELCOME BACK.

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask. Your kindness in furnishing the following information will be appreciated. Please remember that the answers to these questions are held in strict confidence.

NAME _____ **Date** _____
Last First MI

Please Circle: Single Married Male Female **SS#** _____ **BIRTH DATE** _____
Month Date Year

TELEPHONE _____ **Cell Phone** _____
Home # Work #

ADDRESS _____
Street Apt# City State Zip

PLACE OF EMPLOYMENT _____ **ADDRESS**_____

If MINOR, PARENT/GUARDIAN NAME _____ **PARENT'S SS#** _____

PARENT'S BIRTH DATE _____ **PARENT'S PLACE OF EMPLOYMENT**_____
Month Date Year

PHYSICIAN NAME _____ **TELEPHONE** _____

ADDRESS _____

Please Circle Yes or No. If yes, please explain.

Yes / No Are you under medical treatment now or been hospitalized within the last 5 years?
If so, for what? _____

Yes / No Have you had any major operations? If so, what? _____
Yes / No Have you had abnormal bleeding after cuts, surgery, or dental extractions?
Yes / No Have you undergone surgery or chemo/radiation of the head and neck area?
Yes / No Are you currently using any tobacco products? Type: _____ How often? _____
Yes / No Are you currently using any alcohol products? Type: _____ How often? _____
Yes / No Are you currently using any recreational drugs? Type: _____ How often? _____
Yes / No Are you in good health at this time?
Yes / No **Women:** Are you pregnant at this time? If yes, what is your due date? _____
Yes / No Is there any condition you feel your dentist should know about before undertaking dental treatment?
Explain. _____

DO YOU HAVE, OR HAVE YOU EVER HAD: (CHECK ANY THAT APPLIES):

__ Heart ailment	__ Rheumatic fever or Rheumatic heart disease	__ Heart attack
__ High blood pressure	__ Artificial heart valve or prosthesis	__ Ankle swelling
__ Respiratory or lung disease	__ Tuberculosis	__ Asthma
__ Emphysema	__ Any blood disease	__ Liver disease
__ Diabetes (Type? ___)	__ Arthritis	__ Stroke
__ Hepatitis	__ Fainting or seizures	__ Glaucoma
__ Allergy	__ Acid Reflux/GERD	__ HIV
__ Cancer/Tumors	__ STDs	__ Thyroid problem
__ Hormone deficiency	__ Tumor or growth	__ Sinus trouble
__ Persistent cough	__ Recurrent sore throat	__ Heart murmur
__ Mitral valve prolapse	__ Artificial Joints (hip, knee, etc.)	__ Anxiety or Depression

Please provide us with a comprehensive list of any medications or dietary supplements you are currently on below, or on a separate form to be brought to your first appointment.

For medications: please list name, dosage, and reason for taking.

_____
_____
_____
_____
_____

What pharmacy do you use?

Name: _____ **Telephone**: _____

Location: _____

ARE YOU ALLERGIC TO, OR HAVE YOU EVER REACTED ADVERSELY TO: (CHECK ANY THAT APPLIES):

__ Local Anesthetic (such as Lidocaine)
__ Penicillin
__ Sulfa Drugs
__ Aspirin or Codeine
__ Sedative, Barbiturates, or Sleeping pills
__ Other? _____

DENTAL HISTORY

Reason for visit: _____

When was your last dental visit? _____

Yes / No Have you ever had any serious problem associated with previous dental treatment?
Yes / No Do your gums bleed easily?
Yes / No Do you ever get canker sores in your mouth? How often? _____
Yes / No Do you feel that you can chew adequately?
Yes / No Do you find it difficult to open your mouth widely?
Yes / No Do you have any difficulty in swallowing?
Yes / No Have you had Nitrous Oxide (laughing gas) during dental treatment previously?
Yes / No Have you had any injuries to the head, neck, or jaw?
Yes / No Do you have frequent headaches?
Yes / No Do you grind or clench your teeth?
Yes / No Have you ever had a sleep study done?
Yes / No Have you ever had to premedicate for dental visits? If so, what condition? _____

Are your teeth painful to: (Circle all that apply)

Hot Cold Touch Chewing Sweets

Emergency Contact Outside Of Immediate Family Household

Name _____
First Last Address City State Zip

Telephone: _____

The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right for Whitaker Family Dentistry, Inc. to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

_____
Patient or Responsibly Party Date