LINDEN HILLS DENTISTRY

Today's Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

DENTAL HISTORY

Previous Dentist: _____ Last Treatment: _____

What is most important to you in terms of what you expect from our office:

_____

Top priorities for your dental care: Ideal Dentistry Basic Maintenance Other: _____

Do you have any current dental concerns? Yes (*Explain*) No

_____

What is your daily routine? Brushing _____ Flossing _____

Do you wear a night guard? Yes No

Do you take a premedication prior to dental visits? Yes (*Explain*) _____ No

Are you the type of person who likes a lot of detailed information *or* do you prefer more bottom line information? _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT ARE CURRENTLY A CONCERN FOR YOU:

Appearance of teeth	Bleeding gums	Grind/Clench teeth
Pain or discomfort	Mouth Sores	Joint Pain
Cold/Heat Sensitivity	Bad Breath	Headaches
Pressure Sensitivity	Food Collects	Dry Mouth
Sweet Sensitivity	Tobacco User	Other: _____

COMMENTS:

_____

To the best of my knowledge, all of the preceding answers are true and correct on the front and back of this form. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR AT THE NEXT APPOINTMENT WITHOUT FAIL.

-OVER PLEASE TO COMPLETE MEDICAL HISTORY-

DO YOU OR HAVE YOU EVER HAD?

(*Please circle all that apply, write in others*)

Joint Replacements:

Yes No

Drug allergies: *List to the right*

Yes No

Heart problems: chest pain, angina, heart attack, congestive heart failure, irregular hear beat, pacemaker, heart valve replacement, damage, prolapse or heart murmur, rheumatic fever, heart bypass surgery

Yes No

Taking blood thinners or have bleeding problems:

Yes No

Lung Problems: Asthma, emphysema, tuberculosis, bronchitis, chronic cough, abnormal chest x-ray, sleep apnea, nebulizer treatment

Yes No

Vascular problems: High blood pressure, low blood pressure, leg bypass surgery

Yes No

Intestinal problems: Acid reflux, hiatal hernia, hepatitis, cirrhosis ulcers, intestinal bleeding

Yes No

Could you be pregnant? Are you nursing?

Yes No

Skin problems: Rash, hives, open sores

Yes No

Nervous System problems: Seizures, paralysis, numb areas, stroke, weakness, migraines, confusion, fainting, anxiety, depression, bipolar disease, dementia, Alzheimer's, autism

Yes No

Endocrine problems: Diabetes type I, II , thyroid, low blood sugar

Yes No
A1C # _____
If diabetic controlled by: diet oral meds insulin

Immune system problems: Rheumatoid arthritis, lupus, HIV, Sjogren's

Yes No

Cancer/Chemotherapy/X-Ray Treatment:

Yes Diagnosis: _____When: _____ No

ALLERGIES

Are you allergic to or have you ever had an adverse reaction to:

- Latex or rubber products? Yes No
- Other allergies to medications? *Please list:*

_____ Reaction _____

_____ Reaction _____

_____ Reaction _____

_____ Reaction _____

_____ Reaction _____

MEDICATIONS *Please list:* None

Include over the counter and herbal medications

_____ Dose/Freq _____

_____ Dose/Freq _____

_____ Dose/Freq _____

_____ Dose/Freq _____

_____ Dose/Freq _____

_____ Dose/Freq _____

_____ Dose/Freq _____

PREVIOUS SURGERIES/HOSPITALIZATIONS/YEAR

Anesthetic problems/family history/muscle weakness/high fevers after anesthesia

_____

Yes No

IMMUNIZATIONS:

Tetanus/year Yes No
Hepatitis B/year Yes No

PERSONAL/SOCIAL HISTORY:

Do you smoke or chew tobacco?
Yes No

Do you consume more than 5 alcoholic beverages in a day?
Yes No

Recreational/Street Drugs
Yes (*Explain*) _____ No

DO YOU HAVE any other disease, condition or problem, not listed above that you think the doctor should know about?

Yes (*Explain*) _____ No

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Doctor/Staff Initials Date