Linden Hills DENTISTRY

Today's Date: ________________

Patient Name: ________________________________ Birthdate: ________________

DENTAL HISTORY

Former dentist: ________________________________

Last treatment date: ________________________________

Please check 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: ________________________________

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– OVER PLEASE –

Updates (Staff Use Only) Note changes in medical or dental history, or address and phone number.		❑ No Change Signed:	❑ Refer Progress Notes Date:	❑ No Change Signed:	❑ Refer Progress Notes Date:
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Confidential Medical History

1. Family Physician ______________________ Specialist ______________________

2. Date of your last physical exam ______________________

3. Have you ever had excessive bleeding requiring special treatment following medical/dental surgery? . . . ❑ Yes ❑ No

4. Do you regularly take medication or drugs of any kind? (prescription or non-prescription) . . . . ❑ Yes ❑ No

   If yes, please list: ______________________ ______________________

   ______________________ ______________________

   ______________________ ______________________

   ______________________ ______________________

   ______________________ ______________________

5. Are you on a special diet? . . . . ❑ Yes ❑ No

6. WOMEN: Are you pregnant now? . . . . ❑ Yes ❑ No

   Are you taking oral contraceptives? . . . . ❑ Yes ❑ No

7. Do you have heart trouble? . . . . ❑ Yes ❑ No

   ❑ Heart Failure
   ❑ Heart Disease or Attack
   ❑ Angina Pectoris
   ❑ Heart Valve or Surgery
   ❑ Heart Murmur
   ❑ Heart Pacemaker
   ❑ Congenital Heart Lesions
   ❑ High Blood Pressure
   ❑ Low Blood Pressure

8. Check any of the following which you have had or have at present:

   ❑ Anemia
   ❑ Bleeding Problems
   ❑ Stroke
   ❑ Diabetes
   ❑ Epilepsy or Seizures
   ❑ Scarlet Fever
   ❑ Rheumatic Fever
   ❑ Hemophilia
   ❑ Bulemia
   ❑ Anorexia
   ❑ Artificial Joint
   ❑ Ulcer
   ❑ Glaucoma
   ❑ Sinus Condition
   ❑ Asthma
   ❑ Cough
   ❑ Emphysema
   ❑ Tuberculosis (T.B.)
   ❑ Radiation Therapy to Head or Neck
   ❑ Chemotherapy (Cancer/Leukemia)
   ❑ Colitis
   ❑ Arthritis
   ❑ Rheumatoid Arthritis
   ❑ Fainting or Dizzy Spells
   ❑ Psychiatric Treatment
   ❑ Bruise/Swell Easily

   Diseases:
   ❑ Cancer
   ❑ Kidney
   ❑ Liver
   ❑ Thyroid or Parathyroid
   ❑ Sickle Cell
   ❑ Chemical Dependency

   Allergies (Drugs):
   ❑ Penicillin
   ❑ Local Anesthetic
   ❑ Aspirin
   ❑ Codeine
   ❑ Latex
   ❑ Other

   Infectious Diseases:
   ❑ Positive AIDS Antibody Test
   ❑ Hepatitis A (Infectious)
   ❑ Hepatitis B (Serum)
   ❑ Hepatitis C
   ❑ Cold Sores

9. Any serious illness not listed? ______________________

To the best of my knowledge, all of the preceding answers are true and correct. 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.

______________________ ______________________

Signature of Patient, Parent or Guardian Date

______________________ ______________________

Doctor/Staff Signature Date