Whispering Pines Dental Lodge — Medical History

Patient Name: _____ Date: _____

Current Medications & Supplements - ☐ Please indicate if separate list provided

_____

_____

Allergies & Symptoms: _____

Primary Care Physician: _____ Phone#: _____

Are you under the care of a specialist? Yes No - Please Specify: _____

Although some of the folllowing questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.

Do you have any of the following:

Heart Problems..... Yes No
If yes, please describe: _____
High Blood Pressure..... Yes No
Low Blood Pressure..... Yes No
Pacemaker..... Yes No
Artificial Heart Valve..... Yes No
Joint Replacement..... Yes No
If yes, please describe: _____
Is an antibiotic pre-med required before treatment?..... Yes No
If so, what type, dosage? _____
Easy Bruising..... Yes No
Abnormal Bleeding..... Yes No
Frequent Nose Bleeds..... Yes No
Anemia..... Yes No
History of Blood Transfusion..... Yes No
History of Stroke or TIA..... Yes No
Sinusitis..... Yes No
Asthma..... Yes No
Tuberculosis..... Yes No
COPD..... Yes No
Hepatitis, Type:____..... Yes No
Liver Problems..... Yes No
Kidney Problems..... Yes No
Bladder Problems..... Yes No
Ulcers/GERD..... Yes No
Gallstones or Gallbladder Problems..... Yes No
Arthritis..... Yes No
Back or Neck Pain..... Yes No
Osteoporosis..... Yes No Osteopenia..... Yes No
High Cholesterol..... Yes No
History of Fainting..... Yes No
History of Seizures..... Yes No

Epilepsy or other Neurological Disorder..... Yes No
If other, what? _____
History of Head Trauma..... Yes No
Frequent or Severe Headaches/Migraines.. Yes No
Thyroid Concerns..... Yes No
Diabetes, Type:_____,HbA1c:_____ Yes No
Family History of Diabetes..... Yes No
Excessive Thirst..... Yes No
Dry Mouth..... Yes No
Oral Herpes or Cold Sores..... Yes No
HIV+/Aquired Immune Deficiency Syndrome... Yes No
Have you received an organ transplant?..... Yes No
Have you donated an organ for transplant?..... Yes No
Have you had Cancer?..... Yes No
If yes, type: _____
If yes, Medication/Treatment..... Yes No

Have you taken:

Fosamax/Boniva/Actonel/Zometa?..... Yes No
Depression or Anxiety?..... Yes No
History of Alcohol Abuse..... Yes No
Do you Smoke?..... Yes No
If yes, how often? _____
Do you use Smokeless Tobacco?..... Yes No
If yes, how often? _____
Other Medical Condition/Autoimmune diseases:

_____

Women:

Pregnant, Due Date: _____
Are you Nursing?..... Yes No
Contraceptives or other Hormones..... Yes No

Men:

Do you take Medications for Erectile Dysfunction?..... Yes No
Do you have a History of Prostate Cancer.. Yes No

Do any members of your family have or have they had in the past (please indicate relationship):
☐ Dentures_____ ☐ Periodontal Disease_____

What are your dental goals? _____

Have you ever had any serious trouble associated with a previous dental experience? Please specify: _____

_____

Please list any other comments regarding your teeth, mouth, or dental history: _____

_____

Has there been an accident or medical event that may be the cause for you being here?
If yes, please explain: _____

_____

PATIENT SIG: _____ DATE: _____ DR. SIG: _____ DATE: _____