MEDICAL HISTORY

Patient Name: ______________________ Date of Birth: __/__/___

Medical Doctor Name: ______________________ Last Physical Exam: __/__/___

PLEASE ANSWER THE FOLLOWING QUESTIONS

List all medications, herbal remedies, and nicotine replacement therapy that you are taking, including over the counter medications:	List all substances that you are ALLERGIC to:

Do you now have, OR have you ever had, any of the following? Circle 'Y' for yes or 'N' for no:

AIDs	Y N	Epilepsy/Seizures	Y N	Joint replacement	Y N
Anemia	Y N	Fen-Fen Redux	Y N	Kidney disease	Y N
Anxiety disorders	Y N	Gastro-esophageal reflux	Y N	Liver disease	Y N
Arthritis	Y N	Glaucoma	Y N	Psychiatric treatment	Y N
Artificial heart valves	Y N	Heart murmur	Y N	Pacemaker	Y N
Asthma	Y N	Heart surgery	Y N	Sensitivity to metals or latex	Y N
Bisphosphonates (Fosamax)	Y N	Heart trouble	Y N	Sexually transmitted diseases	Y N
Osteoporosis treatment	Y N	Hepatitis (type ______)	Y N	Sinus trouble	Y N
Cancer or tumor	Y N	High blood pressure	Y N	Stroke	Y N
Diabetes	Y N	HIV positive	Y N	Tuberculosis	Y N

1. Have you been treated by a physician or hospitalized in the past year? .... Y N
   If Y, explain: ____________________
2. Has there been any change in your general health in the past year? .... Y N
   If Y, explain: ____________________
3. Are you experiencing any unresolved stress? .... Y N
4. Have you ever had any unusual reaction to "Novocain" or other local anesthetic? .... Y N
5. Have you ever had problems with prolonged bleeding from a cut, injury, or tooth extraction? .... Y N
6. Are you in a substance abuse recovery program? .... Y N
7. Have you ever used, or are you currently using any narcotic or recreational drugs? .... Y N
8. Are you pregnant or possibly pregnant? If Y, when due: ____________________ Y N
9. Are you taking birth control pills or other hormones? .... Y N
10. Is there anything related to your health history that you have not indicated above? .... Y N
    If Y, explain: ____________________
11. Have you ever used, or are you currently using, Tobacco? .... Y N
    If Y: How often per day? _________ Start date: __/__/___ Quit date: __/__/___ Would you like to quit? Y N
12. What is the usual amount of alcohol that you consume per day? _____, per week? _____, per month? _____

Patient/Guardian Signature: ______________________________ **Date:** __/__/___

***** Please complete the other side of this form ****

DENTAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Please list your dental complaints, if any: ____________________
   ____
2. What do you want to accomplish in terms of your oral health? ____________________
   ____
3. Are you experiencing any pain or discomfort at this time? .... Y N
4. How do you presently take care of your teeth and gums?
   Flossing Y N How often? _______ Brushing Y N How often? _______ Toothbrush: Hard Soft Power
5. Do you have sensitive teeth? .... Y N
   If so, when: ____________________
6. When was your last visit to a dentist? ____________________
7. What services were provided? ____________________
8. Who was/were your previous dentist(s) (name/city/state): ____________________
   ____
9. How did you hear about this practice?
   Radio (Sidney or Oneonta) Pennysaver Daily Star Internet Sign Friend Coworker Family Other
10. Would you like to learn how to prevent tooth decay and control gum disease? .... Y N

GENERAL RISK – SELF ASSESSMENT

11. Does your mouth seem dry? .... Y N
12. During the day, do you eat and snack on sugary foods, drinks, gum, or mints? .... Y N
13. Are you nervous about having dental treatment? .... Y N
14. Have any of your family members had gum disease? .... Y N
15. Have any of your family members had excessive cavities? .... Y N

PERIODONTAL RISK – SELF ASSESSMENT

16. Have you had, or have you ever been told that you have "gum disease", "deep pockets", or periodontal disease? .... Y N
17. Currently, do you have sore or bleeding gums? .... Y N

CARIES RISK – SELF ASSESSMENT

18. Do you seem to have new cavities at each dental check-up? .... Y N
19. Do you use xylitol or fluoride toothpaste? .... Y N
20. Do you use xylitol or fluoride oral rinse? .... Y N
21. Do you live in an area with fluoridated water? .... Y N
22. Do you have a lot of "fillings"? .... Y N
23. How long ago did you have your last "filling"? ____________________