GREENLAKE FAMILY DENTISTRY

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Medical History

Patient Name: _____ _____ ____ _____

Last First MI Preferred Name

Please select all allergies/conditions that you currently have:

- ☐ *None
- ☐ Allergy - Aspirin
- ☐ Allergy - Penicillin
- ☐ Allergy- Silver
- ☐ Artificial Cardiac Valves
- ☐ Bleeding Disorders
- ☐ Depression
- ☐ Frequent Headache
- ☐ Hearing Aids
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Radiation Treatment
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tumors
- ☐ ADHD
- ☐ Allergy - Codeine
- ☐ Allergy - Seasonal
- ☐ Allergy- Tetracylcline
- ☐ Artificial Joint
- ☐ COPD/Emphysema
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Nervous/ Anxiety
- ☐ Rec. Drug Use
- ☐ Smoker/Chew/Vape
- ☐ Surgery
- ☐ Ulcers
- ☐ Acid Reflux/GERD
- ☐ Allergy - Latex
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Dizziness/Fainting
- ☐ HIV
- ☐ Heart Disease-Angina
- ☐ High Cholesterol
- ☐ Lung Disease
- ☐ Pacemaker/Defib
- ☐ Rheumatism
- ☐ Snoring
- ☐ Thyroid
- ☐ Alcoholism
- ☐ Allergy - Other
- ☐ Allergy -Ibuprofen
- ☐ Arthritis
- ☐ Bisphosphonates
- ☐ Colitis
- ☐ Epilepsy/Seizure
- ☐ HPV/STD
- ☐ Heart Murmur
- ☐ Infective Endorcarditis
- ☐ Mental Disorders
- ☐ Pregnancy/Nursing
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Tuberculosis

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

If any allergies/conditions selected above need further clarification, please describe below:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

Do you require an antibiotic premedication for your dental visits? (Example: joint replacement surgery, heart valve replacement surgery, infective endocarditis). Please list the reason necessary.

_____

_____

For Women:

Are you pregnant, or is there a chance you might be pregnant? ◯ Yes ◯ No

Are you nursing? ◯ Yes ◯ No

Dental Information

With 1 being poor and 5 being excellent, how would you rate the condition of your mouth?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Please list previous dentist(s) name and phone number, if applicable:

What is the date of your most recent dental exam with x-rays: *

I routinely see my dentist:

☐ Every 3 months ☐ Every 4 months ☐ Every 6 months ☐ Once a year ☐ Other

What is your immediate concern?

Is there anything about your smile you would like to change?

Dental History

Do you feel pain on any of your teeth? * ◯ Yes ◯ No

Do your gums bleed while brushing or flossing? * ◯ Yes ◯ No

Are your teeth sensitive to hot, cold, sweet, or sour liquid/ foods * ◯ Yes ◯ No

Pain in jaw, ear, or side of face? * ◯ Yes ◯ No

Have you had any injuries to your head, neck, or jaw? * ◯ Yes ◯ No

Do you clench or grind your teeth? * ◯ Yes ◯ No

Difficulty opening, closing, or chewing? * ◯ Yes ◯ No

Do you drink more than two sodas/carbonated beverages or sports drinks a day? * ◯ Yes ◯ No

If checked "Yes" to any of the above, please explain.

Please list the name and phone number of your physician:

Please list the name and phone number of your preferred pharmacy:

_____

_____

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: _____