

# FRESH DENTAL CARE

## **Why do I need to share a complete medical history with my dentist?**

During your first dental visit, your dentist will ask for a thorough medical history, which typically is included on a patient registration. This history, combined with the results of your initial clinical examination, will help to assess your immediate dental care needs and recommend the best treatment approach.

## **What kind of health information should I share and how specific should I be?**

Mention everything about your health, even if you don't think it relates to your mouth. If you have had surgery or a major illness, be sure to include this information in the medical history of your patient information section.

Many diseases can have significant effects on your mouth and teeth, and researchers continue to discover ways in which oral health is related to overall health. Diabetes, for instance, can increase the risk of periodontal disease.

## **Suggested items to include on your patient registration form:**

- Any recent heart surgery (within the last six months)
- Artificial heart valve(s)
- Asthma
- Congenital Heart defect
- Epilepsy/seizures
- History of rheumatic fever
- History of heart murmur/mitral valve prolapse
- Medications: Prescribed or over-the-counter
- Pacemaker
- Previous bacterial endocarditis
- Systemic pulmonary shunt
- About any allergies you have (including latex allergy)
- If you are pregnant
- Any health problem or medical condition you are being treated for

## **Should I tell my dentist about any medications I am taking?**

Information about medications you are currently taking can be vital to your health, especially in an emergency. Your health conditions may require us to change the type of anesthesia given. Your dentist also will want to make sure that any medications we prescribe don't interact with medications you already are taking. If you are visiting your dentists for the first time, bring a current list of medications just to be sure your dentist has an accurate record.

## **How often should I update my medical history?**

After your first visit, be sure to keep our office informed any time there is a change in your current health status. Let your dentist know if you are pregnant, have developed allergies or are a smoker.

## **How can I be assured my medical history and records will remain private?**

Our office cannot release any diagnosis or office visit information without your consent. You may be asked to sign a release form so that our office can provide that information to the insurance company for health insurance benefits.

Insurance companies are required to keep that information confidential from anyone not directly involved with your care or with processing your insurance, just as physicians, hospitals and other health service providers are.

# MEDICAL HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Email \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No  N/A  
Have you ever been hospitalized or had a major operation?  Yes  No  N/A  
Have you ever had a serious head or neck injury?  Yes  No  N/A  
Are you taking any medications, pills, or drugs?  Yes  No  N/A  
Do you take, or have you taken, Phen-Fen or Redux?  Yes  No  N/A  
Are you on a special diet?  Yes  No  N/A  
Do you use tobacco?  Yes  No  N/A  
Do you use controlled substances?  Yes  No  N/A

Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimers Disease     | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sickle cell Disease        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No  N/A

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Condition may require medication N/A . Not answered by patient

## DENTAL HISTORY

Do your Gums Bleed	<input type="radio"/>	Y	<input type="radio"/>	N
Do you have pain, ringing, or popping in or near your ears?	<input type="radio"/>	Y	<input type="radio"/>	N
Do you have pain when chewing or biting?	<input type="radio"/>	Y	<input type="radio"/>	N
Have you experienced any growth or sore spots in your mouth?	<input type="radio"/>	Y	<input type="radio"/>	N
Have you ever had?				
Orthodontics (braces)?	<input type="radio"/>	Y	<input type="radio"/>	N
Local anesthetic?	<input type="radio"/>	Y	<input type="radio"/>	N
Difficult extractions?	<input type="radio"/>	Y	<input type="radio"/>	N
Prolonged bleeding?	<input type="radio"/>	Y	<input type="radio"/>	N
Gum disease?	<input type="radio"/>	Y	<input type="radio"/>	N
A bad dental experience?	<input type="radio"/>	Y	<input type="radio"/>	N
Are you happy with the color of your teeth?	<input type="radio"/>	Y	<input type="radio"/>	N
Have you visited our website?	<input type="radio"/>	Y	<input type="radio"/>	N
Were you satisfied with your previous dental care?	<input type="radio"/>	Y	<input type="radio"/>	N
When was your last dental visit?	_____			
When was your last complete set of dental radiographs taken?	_____			
What can we do to assure a good dental experience here:	_____			
What problems are you having with your mouth?	_____			
Who referred you to our office?	_____			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.