Northwood Dental Associates

510 Northwood Road ◊ Lexington, SC 29072

Medical and Dental History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a very important part of your entire body. Your health conditions and medications can have a large effect on the dental treatment you will receive. Thank you for answering the following questions to the best of your ability. Your honest response will help us to provide you with the safest dental treatment possible. We look forward to getting to know you!

Patient's name: _____ Date of Birth: _____ Today's date: _____

I. CHIEF CONCERN:

Why are you seeking dental care? _____

How did you hear about Northwood Dental Associates? If referred, by whom? _____

II. SOCIAL HISTORY:

Gender: O Male O Female

Occupation: _____ Family members in your home: _____

Emergency contact and phone number(s): _____

Any special needs or accommodations: _____

Family history of diabetes: O Yes O No

Family history of heart disease: O Yes O No

III. MEDICAL HISTORY:

What is your impression of the overall health of your body? O Excellent O Fair O Good O Poor

Are you taking any medications or vitamins? O Yes O No; If yes, please list names and dosages: _____

_____

Are you currently under a physician's care? O Yes O No; If yes, for what are you being treated? _____

_____

When was your last physical examination? _____

Do you see any specialists? If yes, please list: _____

Have you ever had a serious illness, operation, or been hospitalized? O Yes O No; If yes, please explain: _____

_____

Have you ever had a serious injury to your head or neck? O Yes O No; If yes, please explain: _____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No
In the last two years, have you taken or are you now taking steroids (i.e. cortisone)? O Yes O No
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No
Have you ever been told you need to be pre-medicated for dental treatment? O Yes O No

Do you have allergies to any of the following?

O Penicillin O Latex O Sulfa drugs O Metal O Acrylic O Codeine O Other

Please explain: _____

Have you ever had any problems with local anesthetic (i.e. Novocaine)? O Yes O No _____

IV. WOMEN ONLY, are you:

Pregnant or trying to become pregnant? O Yes O No
Currently nursing? O Yes O No
Taking birth control pills, fertility drugs, or hormonal replacement? O Yes O No; If yes, please list: _____

V. BEHAVIORAL HISTORY

Do you or have you ever used tobacco? O Past use O Current use; If yes, how much and for how long? _____

Do you or have you ever used alcohol? O Past use O Social use only O Alcohol dependent; # of drinks per week _____

Do you or have you ever used prescription or street drugs for recreational purposes? O Yes O No; _____

VI. NUTRITIONAL HISTORY

Do you eat a special diet? O Yes O No; If yes, please explain: _____

Have you ever had an eating disorder? O Yes O No; If yes, please explain: _____

How many times per day do you drink or eat things containing refined sugar? _____

What kind of beverages do you typically drink? _____

VII. Do you have or have you had any of the following?

O AIDS/HIV Positive	O Cold Sores/Fever Blisters	O Genital Herpes	O Irregular Heartbeat	O Rheumatic Fever
O Alzheimer's Disease	O Congenital Heart Disease	O Glaucoma	O Kidney problems	O Rheumatism
O Anaphylaxis	O Convulsions	O Hay Fever	O Leukemia	O Scarlet Fever
O Anemia	O Depression	O Head/Eye/Ear/ Nose/Throat Problems	O Liver Disease	O Shingles
O Angina	O Dermatologic problem	O Heart Attack/Failure	O Low Blood Pressure	O Sickle Cell Disease
O Anxiety/Panic	O Diabetes Type I	O Heart Murmur	O Lung Disease	O Sinus Trouble
O Arthritis/Gout	O Diabetes Type II	O Heart Pacemaker	O Mitral Valve Prolapse	O Spina Bifida
O Artificial Heart Valve	O Drug Addiction	O Heart Failure	O Mouth Ulcers	O Stomach/Intestinal Problems
O Artificial Joint(s)	O Easily Winded	O Hemophilia	O Neurologic/Nerve problems	O Stroke
O Asthma	O Emphysema	O Hepatitis A	O Osteoporosis	O Swelling of Hands/Feet
O Bleeding Problems	O Epilepsy/Seizures	O Hepatitis B or C	O Parathyroid Disease	O Thyroid Disease
O Blood Disease	O Excessive Thirst	O Herpes	O Prostate Problems	O Tonsillitis
O Blood Transfusion	O Fainting Spells/ Dizziness	O High Blood Pressure	O Psychiatric Care	O Tuberculosis
O Breathing Problems	O Frequent Cough	O High Cholesterol	O Radiation Treatment	O Tumors or Growths
O Bruise Easily	O Frequent Diarrhea	O Hives/Rash	O Recent Weight Loss	O Venereal Disease
O Cancer		O Hypoglycemia	O Renal Dialysis	O Yellow Jaundice
O Chemotherapy		O Immuno-Suppression		
O Chest Pains				

Have you ever had any health condition not listed above? O Yes O No; If yes, please explain: _____

VIII. DENTAL HISTORY

Approximately when was your last dental exam? _____

Approximately when was your last dental cleaning? _____

Have you ever had any trouble associated with previous dental treatment? _____

Are you unhappy with your smile or the appearance of your teeth? _____

Signs/Symptoms:

How would you describe your current dental problem(s), if any? _____

Are you currently experiencing dental pain or discomfort?	O Yes O No
Are your teeth sensitive to hot, cold, sweets, or pressure?	O Yes O No
Do you have any loose teeth?	O Yes O No
Have you noticed your teeth moving or shifting recently?	O Yes O No
Do you have trouble chewing?	O Yes O No
Have you recently noticed any swelling around your mouth, face, or neck?	O Yes O No
Do you ever get sores or ulcers in your mouth?	O Yes O No
Do you have dry mouth?	O Yes O No

Oral Hygiene:

How often do you brush your teeth?	O < 1 time/day O 1 time/day O 2 times/day O > 2 times/day
What kind of toothbrush do you use?	O Manual O Electric
How often do you floss your teeth?	O Rarely O 1 time/week O 1 time/day O > 1 time/day
Do your gums bleed when you brush your teeth?	O Rarely O Sometimes O Always
Do you have trouble cleaning or caring for your teeth?	O Yes O No

TMJ:

Do you ever have headaches, earaches, or neck pain?	O Yes O No
Do you have clicking, popping, discomfort, or limited opening in your jaw joints?	O Yes O No
Do you ever clench or grind your teeth?	O Yes O No
Have you ever been treated for jaw joint problems?	O Yes O No

Additional Info:

Have you ever had a serious injury to your head or mouth?	O Yes O No
Do you participate in recreational activities or sports?	O Yes O No
Are you nervous or do you have high anxiety regarding your dental treatment?	O Yes O No

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 health. It is my responsibility to inform Northwood Dental Associates of any changes in my medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____