Parkwest DENTAL

Patient Name: _____

Patient Birthdate: _____

MEDICAL HISTORY

Yes	No	Are you being treated by a physician now? Date of last medical exam _____
Yes	No	Have you ever been hospitalized or had a serious illness? Reason _____
Yes	No	Women, are you pregnant or nursing?
Yes	No	Women, are you taking birth control pills?
Yes	No	**Allergies to medications, anesthesia, latex**
Yes	No	Arthritis, Rheumatism,
Yes	No	Artificial Heart Valve
Yes	No	Artificial Joints
Yes	No	Bisphosphonates (Fosamax, Boniva, Actonel, etc.)
Yes	No	Bleeding Problems, Bruising Easily
Yes	No	Cancer, Tumors
Yes	No	Chemotherapy or Radiation
Yes	No	Chest Pain (Angina)
Yes	No	Cholesterol
Yes	No	Congenital Heart Disease
Yes	No	Diabetes
Yes	No	Diarrhea, Constipation, Blood in Stools
Yes	No	Epilepsy or Seizures
Yes	No	Excessive Bleeding
Yes	No	Glaucoma or other eye diseases
Yes	No	Heart Disease (Heart Attacks, Heart Defects, Heart Murmurs, Heart Transplant, Bypass Surgery, Stents, etc.)
Yes	No	Hemophilia or other Blood Disorders (Anemia, Sickle Cell Disease, etc.)
Yes	No	Hepatitis A, B, or C
Yes	No	Herpes
Yes	No	High Blood Pressure
Yes	No	HIV or AIDS
Yes	No	Irregular Heart Beat (Arrhythmia)
Yes	No	Jaundice
Yes	No	Kidney Problems
Yes	No	Liver Disease
Yes	No	Low Blood Pressure
Yes	No	Osteoporosis or Osteopenia
Yes	No	Pacemaker/Defibrillator
Yes	No	Psychiatric care
Yes	No	Respiratory Disease (Asthma, COPD, Emphysema, Tuberculosis, etc.)
Yes	No	Rheumatic Fever
Yes	No	Shortness of Breath
Yes	No	Sinus Problems
Yes	No	Stroke
Yes	No	Thyroid Disease
Yes	No	Ulcers, Stomach Problems
Yes	No	Venereal Disease (Syphilis, Gonorrhea, etc.)

Please list any medications you are currently taking _____
_____
_____

Do you have, or have had, any of the following (please circle):

Blood transfusions, Blurred vision, Contact lenses, Difficulty swallowing, Difficulty urinating or blood in urine, Dizziness, Excessive thirst, Headaches, Fainting spells, Fever or night sweats, Frequent diarrhea or blood in stools, Frequent urination, Frequent vomiting or nausea, Join pain or stiffness, Persistent cough or coughing up blood, Recent weight loss, Ringing in ears, Skin diseases, Swollen ankles, Surgeries

DENTAL HISTORY

When was your last cleaning?		
How often do you have your teeth cleaned?		
Have you had any problems with prior dental treatment?	Yes	No
Are you experiencing dental pain now?	Yes	No
If so, where? ___Upper Left ___Upper Front ___Upper Right ___Lower Left ___Lower Front ___Lower Right		
Is the pain associated with ___Biting ___Sweets ___Cold ___Heat ___Air		
Are you taking medications for this pain?	Yes	No
Do you smoke or chew tobacco, now or in the past?	Yes	No
Are you apprehensive about dental treatment?	Yes	No
Does food become lodged between teeth?	Yes	No
Do you have difficulty chewing your food?	Yes	No
Do you avoid chewing due to pain?	Yes	No
Do you experience pain or bleeding while brushing or flossing?	Yes	No
Does your breath concern you?	Yes	No
Do you experience dry mouth consistently?	Yes	No
Have you ever been diagnosed with periodontal/gum disease?	Yes	No
Have you ever had difficult extractions or prolonged bleeding after extractions in the past?	Yes	No
Have you ever noticed slow healing sores in your mouth?	Yes	No
Do you brush your teeth at least twice a day?	Yes	No
Do you floss at least once a day?	Yes	No
Do you clench or grind your teeth?	Yes	No
Does you jaw hurt when you chew or open it wide to yawn?	Yes	No
Has any medical doctor advised you to take a pre-medication prior to dental care?	Yes	No
Do you wear any type of retainer, nightguard, or removable oral appliance? If yes please describe. _____	Yes	No
Are you interested in whitening your teeth?	Yes	No
What would you change about your smile?_____		
What did you like about your previous dentist? _____		
Emergency Contact _____		
Emergency Number _____		
Medical Doctor _____		
Telephone # _____		

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

RECALL REVIEW:

2021 _____ _____
Patient or Guardian Signature Date

2022_____ _____
Patient or Guardian Signature Date

2023_____ _____
Patient or Guardian Signature Date