STONEGATE MEADOWS
Family, Cosmetic & Implant Dentistry

Date _____

| Name | Date of Birth | Email |
|---|---|---|
| Occupation | Telephone (Home) (Cell) (Work) | |
| Last Medical Examination Blood Taken? | Findings | Physician(s) Name & Telephone |
| General Dentist | Have Family or Friends Been Treated Here? | |

PRESENT DENTAL COMPLAINTS

## DENTAL HISTORY

| | Yes | No |
|---|---|---|
| Do you fear dental treatment | | |
| Have you ever been treated for periodontal disease | | |
| Do you like your smile? | | |
| Do your gums bleed with brushing or flossing? | | |
| Do you have difficulty chewing your food | | |
| Do you grind or clench your teeth | | |
| Do you have a bite guard/splint | | |
| Are spaces developing between your teeth | | |
| Have you noticed your bite changing | | |
| Are you aware of breath odor | | |
| Do you have frequent cold/canker sores | | |
| Do you frequently breathe through your mouth | | |
| Do you have pain in the jaw joints (TMJ) | | |
| Have you ever had orthodontic treatment to straighten your teeth | | |
| Have you ever had problems with extractions | | |
| Does food wedge between your teeth | | |
| Has any member of your family lost all their teeth | | |
| Would you be tremendously disturbed to lose all of your teeth | | |
| Are you having pain or discomfort at this time | | |

When was your last dental cleaning _____

How often have your teeth been cleaned in the past 3 years _____

How long have you been a patient of your present dentist _____

How long have you known about your gum condition _____

Are your teeth sensitive to: Hot _____ Cold _____ Sweet ____

Have you had any "gum boils" or gum swelling Yes ___ No___

Are you satisfied with the appearance of your teeth Yes ___ No ___

If no, why not _____

How would you rate your past dental care _____

Do you desire nitrous oxide during treatment _____

Are you available on short notice for appointments Yes ___ No ___

**Please check any of the following items used in mouth care:**

Hand toothbrush..... _____
Type _____
Electric toothbrush..... _____
Type _____
Proxabrush..... _____
Dental floss ..... _____
Floss holder..... _____
Mouthwashes..... _____
Type _____

Water spray device .. _____
Toothpicks..... _____
Perio Aid..... _____
Stimudents..... _____
Gum stimulator ..... _____
Rubber tip ..... _____
Toothpaste type ..... _____
Other_____

DENTAL HISTORY NOTES .....

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Please print form and bring with you to your first appointment.

| B.P. | Pulse |
|---|---|
| | |

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## MEDICAL HISTORY

| DO YOU HAVE OR HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| Heart attack or stroke | | |
| Arteriosclerosis | | |
| Angina pectoris (Chest pain) | | |
| Shortness of breath | | |
| Swelling in ankles | | |
| High or low blood pressure | | |
| Heart murmur or valve problem | | |
| Rheumatic fever | | |
| Artificial heart valve | | |
| Heart pacemaker | | |
| Abnormal bleeding problems | | |
| Anemia or blood disorder | | |
| Diabetes | | |
| Or family history of | | |
| Hepatitis, jaundice or liver disease | | |
| Thyroid or parathyroid disease | | |
| Stomach or duodenal ulcers | | |
| Kidney disease or infection | | |
| Seizure Disorder (Epilepsy), convulsions or fainting spells | | |
| Glaucoma | | |
| Osteoporosis or osteopenia | | |
| Medication for osteoporosis/osteopenia _____ | | |
| Arthritis or rheumatism | | |
| Artificial joint replacement | | |
| Orthopedic screws, pins, etc. | | |
| Emphysema or chronic bronchitis | | |
| Tuberculosis | | |
| Asthma, hay fever or allergies | | |
| Hives or skin rash | | |
| Allergic to dental anesthetic | | |
| Drug reaction to codeine, tetracycline, penicillin, Demerol, valium, erythromycin, percocet, nitrous oxide, percodan, barbiturates, aspirin, other _____ | | |
| HIV or AIDS | | |
| AIDS antibody (HIV or HTLV_III) positive | | |
| Venereal disease | | |
| Herpes | | |
| Cancer or abnormal growth | | |
| Radiation or chemotherapy | | |
| Surgery | | |
| Hospitalization for illness or surgery (list below) (Within the past 5 years) | | |

| DO YOU HAVE OR HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| Anticoagulants (blood thinners) | | |
| Do you bruise easily | | |
| Blood transfusion | | |
| Cortisone medication | | |
| Prostate trouble | | |
| Alcoholism | | |
| Drug addiction | | |
| Eating disorder (anorexia, bulimia, etc.) | | |
| Depression | | |
| Any serious illness, disease, condition, not listed (list below) | | |
| **ARE YOU:** | | |
| Presently under a physicians care | | |
| Taking any medication now (list below) | | |
| Or within past year | | |
| Taking vitamins | | |
| Taking herbal supplements or over-the-counter medications (list below) | | |
| Recent unexplained weight change of (10 lbs+) | | |
| Often exhausted or fatigued | | |
| Subject to frequent headaches | | |
| A nervous person | | |
| Under unusual stress | | |
| Taking medication for anxiety/depression | | |
| Taking sleeping medication | | |
| Undergoing psychotherapy | | |
| Do you wear contact lenses | | |
| Do you currently use tobacco products | | |
| Have you used tobacco products in the past | | |

Type _____

Amount _____

**IF FEMALE, are you now (please check if yes)**

Pregnant _____ Nursing _____

Anticipate becoming pregnant _____

Presently in (or post) menopause _____

Taking oral contraceptives _____

Hormone Replacement Therapy _____

MEDICAL HISTORY NOTES.....

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To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the doctor or his/her staff at the next appointment without fail.

DATE: _____

PATIENT'S SIGNATURE_____
(Guardian/Parent if minor)