

# Lalor Creekside Dental

Medical History

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

1. Are you under the care of a physician currently? Yes No  
a. Physician's Name \_\_\_\_\_  
b. Physician's Number \_\_\_\_\_
  
2. Are you currently taking any medications, pills, or drugs? Yes No  
Please list all: \_\_\_\_\_  
\_\_\_\_\_
  
3. Are you required to take antibiotic pre-medication for dental procedures due to an existing condition? \_\_\_\_\_ why? \_\_\_\_\_
  
4. WOMEN ONLY: Are you pregnant or nursing? Yes No
  
5. Please list any allergies you have: \_\_\_\_\_  
\_\_\_\_\_

6. Please CIRCLE if you have, or have you had, any of the following

Artificial Heart Valve  
High Blood Pressure  
Heart Attack/Heart Failure  
Heart Murmur  
Heart Pace Maker  
Endocarditis  
Mitral Valve Prolapse  
Congenital Heart Disease  
Artificial Joint- when? \_\_\_\_\_  
Emphysema  
Diabetes  
Stroke  
Epilepsy/Seizures  
Asthma  
Lupus  
Other: \_\_\_\_\_  
\_\_\_\_\_

Arthritis  
Tuberculosis  
HIV/AIDS  
Alzheimers Disease  
Psychological Disorders  
Hepatitis  
Liver Disease  
Chemotherapy  
Radiation Therapy  
Excessive Bleeding  
Hemophilia  
Kidney Problems  
Rheumatic/Scarlet Fever  
Acid Reflux

7. Please list below any hospitalizations/ surgical procedures you have had:

\_\_\_\_\_  
\_\_\_\_\_

*(please turn over)*

## Dental History

Please **CIRCLE** any of the following problems that apply to you:

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in your mouth

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

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates:

- Your last cleaning \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_
- Your last complete X-Rays \_\_\_\_\_

Name of previous Dentist \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_

Why did you leave your previous Dentist?  
\_\_\_\_\_

Patient Signature (Parent of Child) \_\_\_\_\_ Date \_\_\_\_\_

Do you smoke or use chewing tobacco?

how much? \_\_\_\_\_ how long? \_\_\_\_\_

If you could change your smile, you would:

- Make it whiter
- Make it straighter
- Close spaces
- Replace metal fillings with natural, tooth-colored
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1-10, with 10 being the highest:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health? \_\_\_\_\_

What is the most important thing to you about your dental visit today? \_\_\_\_\_

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## OFFICE USE ONLY

### Health History Updates/Notes

Date	note

## ANESTHESIA LIMITATIONS