# CEDAR ISLAND DENTAL MEDICAL AND DENTAL INFORMATION (Adult/Teen)

Patient's Name: _____ Birth date: ___/___/___ Date: ___/___/___

## DENTAL HISTORY:

Reason for today's visit: _____

Previous dentist's name, address, and phone #: _____

Date of last dental visit: ___/___/___ Date of last dental x-rays: ___/___/___

Do you have any current dental concerns? Yes □ No □ If yes, explain: _____

How do you feel about the appearance of your teeth? Happy □ Unhappy □

Have you had any difficulty associated with past dental work? Yes □ No □ If yes, explain: _____

How often do you brush? _____ How often do you floss? _____

Please check any of the following that apply to you now or in the past:

| | | | | | |
|---|---|---|---|---|---|
| Bite is off | ___ | Mouth breathing | ___ | Sinus problem | ___ |
| Clench or grind your teeth | ___ | Orthodontic treatment | ___ | Sleep apnea | ___ |
| Cold sensitivity | ___ | Pain or popping in your jaw | ___ | Smoker/chewing tobacco | ___ |
| Gums bleed | ___ | Periodontal treatment | ___ | Unpleasant taste | ___ |
| Hot sensitivity | ___ | Pressure sensitivity | ___ | | |

## MEDICAL HISTORY:

Physician's Name: _____ Phone Number: _____ Date of Last Visit: ___/___/___

Are you currently under the care of a physician? Yes □ No □ If yes, explain: _____

Your current physical health is: Good □ Fair □ Poor □

Please list any prescription and over-the-counter medications you take: _____

Do you or have you ever taken Fosamax or any bisphosphonate? Yes □ No □ Have you ever taken Phen-fen? Yes □ No □

Have you ever been advised to take antibiotics before a dental appointment? Yes □ No □

For women: Are you using prescribed birth control medication? Yes □ No □

Are you pregnant? Yes □ No □ If yes, week # _____ Are you nursing? Yes □ No □

Please check any of the following that apply to you now or in the past:

| | | | | | |
|---|---|---|---|---|---|
| Abnormal bleeding | ___ | Fainting spells | ___ | Mitral valve prolapse | ___ |
| Abnormal blood pressure | ___ | Healing complications | ___ | Psychiatric care | ___ |
| Angina (take nitro) | ___ | Heart attack | ___ | Radiation treatment | ___ |
| Asthma/ allergies | ___ | Heart murmur | ___ | Respiratory disease | ___ |
| Blood disease | ___ | Heart valve implant | ___ | Rheumatic fever | ___ |
| Cancer | ___ | Hepatitis/liver problems | ___ | Rheumatism/arthritis | ___ |
| Chemically dependent | ___ | HIV/AIDS | ___ | Sinus problem | ___ |
| Chemotherapy | ___ | Joint replacement | ___ | Stomach, intestinal disorders | ___ |
| Congenital heart disorders | ___ | Kidney disease | ___ | Stroke | ___ |
| Congestive heart failure | ___ | Lupus | ___ | Thyroid disease | ___ |
| Diabetes | ___ | Major illness/accident | ___ | Tuberculosis | ___ |
| Epilepsy | ___ | Major surgeries | ___ | Venereal disease | ___ |

Would you like to speak to the doctor privately about any problem? Yes □ No □

Please check if you are allergic to any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Aspirin | ___ | Erythromycin | ___ | Penicillin | ___ |
| Codeine | ___ | Jewelry/metals | ___ | Tetracycline | ___ |
| Dental anesthetics | ___ | Latex | ___ | Other | ___ |

I certify the above information is complete and accurate. It is my responsibility to inform this office of any changes in my medical history.

_____ _____

Patient's/Guardian's signature Date