

Welcome to West Ashley Family Dentistry!

Patient Medical and Dental History Form

Please take a few minutes to carefully read over and answer the following questions to help us treat you safely.
If you have any questions, we will be glad to assist you.

Patient Name: _____ Birthdate: _____ Today's Date: _____
Current Address: _____ Phone Number: _____

Dental History

Reason for today's visit: _____
Former Dentist: _____ City: _____ State: _____
Date of last dental visit: _____ Date of last dental X-rays: _____

Please place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Clicking or popping of jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blisters on mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Burning sensation on tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Clicking or popping of jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaw pain or tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dry mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fingernail biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food stuck between the teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Foreign objects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Grinding teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loose or broken fillings	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is there anything that you would like to change about your teeth? _____

Medical History

Physician's Name: _____ Date of last visit: _____

Please place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bacterial Endocarditis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	what type? _____			Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Abnormally			Hepatitis, type _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
with extractions or surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor or growth on head		
Congenital Heart Lesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	or neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous System Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Do you have an allergy to Aspirin Barbituates (sleeping pills) Codeine Iodine Latex
Local Anesthetic Penicillin Sulfa Other: _____

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date: _____ Are you nursing? Yes No
Taking Birth Control Pills? Yes No

Please list any medications you are currently taking and what you are taking it for: _____

Pharmacy Name: _____ Phone: _____