ERBES
FAMILY DENTAL CENTER

- Full Mouth Rehabilitation
- TMJ/Occlusal Disorders
- Cosmetic Dentistry
- Implant Prosthetics

Medical History

Date _____

Name _____ I prefer to be called _____

Street Address _____ Email _____

City _____ State _____ ZIP _____

Home Phone (_____) _____ Bus. Phone (_____) _____ Cell Phone (_____) _____

Occupation _____

Date of Birth _____/_____/_____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced Name of Spouse _____

Closest Relative _____ Phone (_____) _____

If completing this form for another person, what is your relationship to that person? _____

Who were you referred by? _____

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? . . . . . ☐ Yes ☐ No
2. Has there been any change in your health within the last year? . . . . . ☐ Yes ☐ No
3. My last physical examination was on _____
4. Are you under the care of a physician? . . . . . ☐ Yes ☐ No

   If yes, what is the condition being treated? _____
5. The name(s) of my physician(s) is _____

   _____
6. Have you had a serious illness, operation, or been hospitalized in the past 5 years? . . . . . ☐ Yes ☐ No

   If yes, what was the illness or problem? _____
7. Are you taking medicine(s) including non-prescription medicine? . . . . . ☐ Yes ☐ No

   If yes, what medicine(s) are you taking? _____

   _____
8. Have you had abnormal bleeding? : . . . . . ☐ Yes ☐ No

   a) Have you ever required a blood transfusion? . . . . . ☐ Yes ☐ No
9. Do you have any blood disorders such as anemia? . . . . . ☐ Yes ☐ No
10. Have you ever had a treatment for a tumor or growth? . . . . . ☐ Yes ☐ No

11. Are you allergic to or ever had a reaction to :

a) Local anesthetics? ☐ Yes ☐ No

b) Penicillin or other antibiotics? ☐ Yes ☐ No

c) Sulfa drugs? ☐ Yes ☐ No

d) Barbituates, sedatives, or sleeping pills? ☐ Yes ☐ No

e) Aspirin? ☐ Yes ☐ No

f) Latex? ☐ Yes ☐ No

g) Codeine or other narcotics? ☐ Yes ☐ No

h) Other? ☐ Yes ☐ No

If yes, what other substances have you had a reaction to? _____

_____

12. Do you have or have you ever had any of the following diseases :

a) Damaged heart valves or artificial heart valves? ☐ Yes ☐ No

b) Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure, arteriosclerosis, stroke, etc)? ☐ Yes ☐ No

1) Do you have chest pain upon exertion? ☐ Yes ☐ No

2) Are you ever short of breath after mild exercise or when lying down? ☐ Yes ☐ No

3) Do your ankles swell? ☐ Yes ☐ No

4) Do you have inborn heart defects? ☐ Yes ☐ No

5) Do you have a cardiac pacemaker? ☐ Yes ☐ No

c) Allergy? ☐ Yes ☐ No

d) Sinus trouble? ☐ Yes ☐ No

e) Asthma or hay fever? ☐ Yes ☐ No

f) Fainting spells or seizures? ☐ Yes ☐ No

g) Diabetes? ☐ Yes ☐ No

h) Hepatitus, jaundice or liver disease? ☐ Yes ☐ No

i) AIDS or HIV infection? ☐ Yes ☐ No

j) Thyroid problems? ☐ Yes ☐ No

k) Respiratory problems such as emphysema, bronchitis, etc.? ☐ Yes ☐ No

l) Arthritis or painful swollen joints? ☐ Yes ☐ No

m) Stomach ulcer or hyperacidity? ☐ Yes ☐ No

n) Kidney trouble? ☐ Yes ☐ No

o) Tuberculosis? ☐ Yes ☐ No

p) Persistent swollen glands in neck? ☐ Yes ☐ No

q) Low blood pressure? ☐ Yes ☐ No

r) Sexually transmitted diseases? ☐ Yes ☐ No

s) Epilepsy or other neurological disease? ☐ Yes ☐ No

t) Problems with mental health? . . . . . ☐ Yes ☐ No

u) Cancer? . . . . . ☐ Yes ☐ No

v) Problems with immune system? . . . . . ☐ Yes ☐ No

w) Are you being treated for osteopenia or osteoporosis? . . . . . ☐ Yes ☐ No

13. Do you have any disease, condition, or problem not listed above that you think I should know about? . . . . . ☐ Yes ☐ No

If yes, explain? _____

14. Why have you come to the dentist today? _____

_____

15. Do you require antibiotics before dental treatment? . . . . . ☐ Yes ☐ No

16. Are you currently in pain? . . . . . ☐ Yes ☐ No

17. Do your gums ever bleed? . . . . . ☐ Yes ☐ No

18. Have you ever had a serious or difficult problem associated with any previous dental work? . . . . . ☐ Yes ☐ No

19. Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? . . . . . ☐ Yes ☐ No

20. Your current dental health is . . . . . ☐ Good ☐ Fair ☐ Poor

21. Do you like your smile? . . . . . ☐ Yes ☐ No

22. Would you like whiter teeth? . . . . . ☐ Yes ☐ No

23. Would you like fresher breath? . . . . . ☐ Yes ☐ No

24. How many times a week do you floss? _____ a day do you brush? _____

25. What type of bristles does your toothbrush have? . . . . . ☐ Soft ☐ Medium ☐ Hard

26. Do you smoke or use tobacco in any other form? . . . . . ☐ Yes ☐ No

27. Have you ever been diagnosed with periodontal disease? . . . . . ☐ Yes ☐ No

If yes, what treatment received and where? _____

Women

28. Are you pregnant? . . . . . ☐ Yes ☐ No

29. Are you nursing? . . . . . ☐ Yes ☐ No

30. Are you taking birth control pills? . . . . . ☐ Yes ☐ No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature of Patient/Guardian _____

For completion by the dentist:

Comments on patient interview concerning medical history: _____

_____

Date_____ Signature of Dentist _____