Greenbelt Dental Health

Advanced Biologic Dentistry

https://www.greenbeltdentalhealth.com/

Medical History

(This information will be held in strict confidence)

Date: _____

Name:_____Preferred name: _____

Date of Birth: _____ Gender: M F
Marital Status: S M D W _____ Spouse's Name: _____
Address:_____City, State, Zip: _____
Home #:_____ Work #:_____ Cell #:_____
Email: _____
Emergency contact & phone: _____
Referred By: _____

Dental Questionnaire

Date of most recent dental visit_____

Does dental treatment make you nervous? ____No ____Somewhat_____Extremely

My mouth is: Very comfortable / moderately comfortable / Uncomfortable

I think the appearance of my mouth is: Excellent / Satisfactory / Unsatisfactory

Do you use the following? Toothbrush / Dental Floss / Oral Irrigator / Other _____

How often do you brush?_____Do you use a soft toothbrush? Y / N

Have you ever been treated for periodontal disease (gum disease)? Y / N

Do you have, or have you ever experienced the following?

Y / N	Bleeding, sore gums	Y / N	Loose Teeth
Y / N	Unpleasant taste/bad breath	Y / N	Sensitive to hot
Y / N	Burning tongue/lips	Y / N	Sensitive to cold
Y / N	Frequent mouth blisters	Y / N	Biting sensitivity
Y / N	Swelling/Lumps in mouth	Y / N	Food Impaction
Y / N	Orthodontic treatment (braces)	Y / N	Shifting in bite
Y / N	Biting cheeks/lips	Y / N	Clenching / Grinding- when? _____
Y / N	Clicking/Popping jaw		

Y / N Are you having any discomfort at this time? If yes, explain_____

_____

Y / N These are the things that are important to me regarding my dental health, _____

_____

Health Questionnaire

Are you in good health? Y / N
If not, explain briefly _____

Are you under a physician's care now? Y / N
If yes, please explain_____
Name of health care practitioner_____Date of last Physical_____

Have you had any serious illness or operations? Y / N
If yes, please explain_____

Are you taking any medications? Including OTC supplements Y / N If yes, please list: _____
_____

Are you allergic OR have you reacted adversely to:

____ Aspirin _____ Sulfa drugs _____ Latex _____ Penicillin or other antibiotics_____
____ Iodine _____ Local anesthetics _____ Codeine or other analgesic_____

Allergies to other meds: _____

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

Y / N	Anemia	Y / N	Hearing/Vision Loss
Y / N	Arthritis	Y / N	Hemophilia
Y / N	Asthma	Y / N	Hepatitis A___B_____C _____
Y / N	Blood Transfusion	Y / N	Herpes
Y / N	Breathing Problems	Y / N	High Cholesterol
Y / N	Bruise Easily	Y / N	Hives/Skin Rash
Y / N	Cancer _____	Y / N	Joint Pain/Inflammatory Rheumatism
Y / N	Chemotherapy	Y / N	Joint Replacement _____
Y / N	Chronic Fatigue Syndrome	Y / N	Kidney Problems
Y / N	Cold Sores/Fever Blisters	Y / N	Lung Disease
Y / N	Diabetes (Do you take Insulin? Y/N	Y / N	Multiple Chemical Sensitivity
Y / N	Drug Addiction	Y / N	Psychiatric Care
Y / N	Emphysema	Y / N	Radiation
Y / N	Environmental Sensitivities	Y / N	Sexually Transmitted Disease
Y / N	Epilepsy or Seizures	Y / N	Stroke
Y / N	Epstein Barr Virus	Y / N	Thyroid Disease
Y / N	Excessive Bleeding	Y / N	Tobacco – Type_____How often? _____
Y / N	Fibromyalgia	Y / N	Tuberculosis
Y / N	Frequent Headaches	Y / N	Ulcers
Other – not listed _____		Y / N	Vertigo

_____

HEART: Y / N	Congenital Heart Lesions	Y / N	Cardiovascular Disease
Y / N	Rheumatic Fever	Y / N	Heart Murmur
Y / N	High Blood Pressure	Y / N	Mitral Valve Prolapse
Y / N	Low Blood Pressure	Y / N	Do you have a pacemaker?
Y / N	Irregular Heart Beat	Y / N	Are you on blood thinners?

WOMEN: Y / N Pregnant Y / N Nursing Y / N Taking oral contraceptive

Signature of Patient, Parent or Guardian_____ Date _____

Signature of Dentist _____Date _____