goose creek
village dental

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Medical Questions

Are you in good health?	Y	N
Has there been any changes to your general health in the past year?	Y	N
Date of last physical exam:		
Are you now under a physician's care for a particular problem?	Y	N
Have you ever had any serious illness, operations or hospitalizations? If so, describe:	Y	N
DO YOU HAVE OR HAVE YOU EVER HAD:		
Rheumatic Fever / Rheumatic Heart Disease?	Y	N
Congenital Heart Disease?	Y	N
Cardiovascular Disease? (ex: heart attack, heart trouble, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker?)	Y	N
Heart Murmur / Mitral Valve Prolapse?	Y	N
Lung Disease? (ex: asthma, emphysema, bronchitis, pneumonia, tuberculosis?)	Y	N
Seizures, Convulsions, Epilepsy, Fainting, Dizziness?	Y	N
Bleeding Disorder, Anemia, Bleeding Tendency?	Y	N
Liver Disease (ex: jaundice, hepatitis)?	Y	N
Kidney Disease?	Y	N
Diabetes?	Y	N
Thyroid Disease?	Y	N
Arthritis?	Y	N
Stomach Ulcers or Colitis?	Y	N
Glaucoma?	Y	N
Implants placed anywhere in your body? (ex: heart valve, pacemaker, plates, pins, screws)	Y	N
Joint replacement (hip, knee)? If so, date:	Y	N
Sinus or Nasal Problems?	Y	N
Any disease, drug or transplant operation that has depressed your immune system?	Y	N
Do you snore or have sleep apnea?	Y	N

ARE YOU USING ANY OF THE FOLLOWING:		
Anticoagulants / Blood Thinners	Y	N
Digitalis, Nitroglycerin, or other heart medications?	Y	N
Are you taking or have you taken Bisphosphonates (ex: Fosamax or Actonel) for osteoporosis or chemotherapy?	Y	N
Please list all medications you are taking:		
ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD AN ADVERSE REACTION TO:		
Local Anesthesia (ex: novocaine)?	Y	N
Penicillin or other antibiotics?	Y	N
Latex or rubber products?	Y	N
Codeine, hydrocodone or any other narcotic?	Y	N
Other allergies or reactions? If so, please list:	Y	N
Do you drink alcohol?	Y	N
Do you smoke or use smokeless tobacco?	Y	N
Do you have a history of alcohol or drug abuse?	Y	N
Have you ever taken antibiotics prior to dental treatment?	Y	N
Do you have any other disease, condition or problem not listed above?	Y	N
FOR WOMEN ONLY:		
Are you pregnant, or is there a chance that you might be pregnant?	Y	N
Are you nursing?	Y	N
Are you using Oral Contraceptives?	Y	N

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Dental Questions

What is the reason for your visit today?		
Date of last dental exam?		
Date of last dental x-rays?		
Have you had serious problems associated with dental treatment in the past?	Y	N
Have you had injury to your face, jaws or teeth?	Y	N
Have you received radiation to your head or neck?	Y	N
Do you get cold sores?	Y	N
Do you have dry mouth?	Y	N
Is your home water supply fluoridated?	Y	N
Do you drink bottled or filtered water?	Y	N
Do you have any dental implants?	Y	N

Does your jaw pop or click when you eat or chew?	Y	N
Do you grind your teeth?	Y	N
Do you play sports?	Y	N
Are your teeth sensitive to hot, cold sweets or biting?	Y	N
Do your gums bleed when you brush or floss?	Y	N
Have you had:	Y	N
Orthodontic treatment (braces)?	Y	N
Wisdom teeth removal?	Y	N
Root canal treatment?	Y	N
Gum disease treatment?	Y	N
Do you have any complete or partial dentures? If so, when were they made?	Y	N
Do you have any tooth or teeth replaced by bridges?	Y	N
Are you satisfied with the appearance of your teeth and smile?	Y	N

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about 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 action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient / Guarantor Date

_____

Signature of Dentist Date