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New Patient Medical History Update

TrimbleDental
Something to smile about

New Patient Medical History

Patient's Name: ______________________ Name of your previous Dentist: ______________________:

When was your last cleaning? ______________ City: ______________ State: ______ Phone: ______________

Check the following problems that apply.

- -Sensitivity (hot, cold, sweet, pressure) ☐
  Where? **UL LR UL LL**
- -Headaches, earaches, neck pain ☐
- -Jaw joint pain ☐
- -Teeth or fillings breaking ☐
- -Grinding or clenching teeth ☐
- -Bleeding, swollen or irritated gums ☐
- -Loose, tipped or shifting teeth ☐
- -Bad breath ☐

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

- -Dentures ☐
- -Partial Dentures ☐
- -Braces ☐
- -Periodontal (gum) treatments ☐

-Do you smoke or use chewing tobacco?
How Much? ____________ For how long? ____________

-Any outstanding issues you have with your teeth?

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ON A SCALE OF 1-10 WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Medical History

Please circle any problems or conditions that apply to you:

AIDS	**Dizziness**	**HIV Positive**	**Scarlet Fever**
Allergies (Seasonal)	**Drug Addiction**	**HPV** (Human Papilloma Virus)	**Seizures**
Anemia	**Emphysema**	**Jaundice**	**Sinus Problems**
Angina (Chest Pain)	**Epilepsy**	**Jaw Joint Pain**	**Sleep Apnea**
Arthritis	**Excessive Bleeding**	**Kidney Disease**	**Stomach Problems**
Artificial Heart Valve	**Fainting**	**Liver Disease**	**Stroke**
Artificial Joins	**Glaucoma**	**Low Blood Pressure**	**Thyroid Disease**
Asthma	**Heart Conditions**	**Mitral Valve Prolapse**	**Tuberculosis**
Blood Disease	**Heart Lesions (Congenital)**	**Nervousness/Depression**	**Ulcers**
Bruise Easily	**Heart Murmur**	**Pacemaker**	**Venereal Diseases**
Cancer	**Heart Surgery**	**Pregnant Currently**	**Other:** ______________
Cervical Cancer	**Hepatitis A**	**Radiation (Head/Neck)**	
Chemotherapy	**Hepatitis B**	**Respiratory Problems**	______________
Cortisone Medication	**Hepatitis C**	**Rheumatic Fever**	
Diabetes	**High Blood Pressure**	**Rheumatism**	______________

Are you allergic or have you reacted adversely to any of the following medications? (Please circle all that apply)

Aspirin, Darvon, Nitrous Oxide, Percodan, Latex, Local Anesthetic, Tetracycline, Codeine, Erythromycin, Valium, Penicillin, Sulfa

Other: ______________________

Have you ever taken any of the following medications? (Please circle all that apply)

Actonei, Aredia, Fosamax, Reclast, Zometa, Boniva, Herbal, Supplements

Date of your last Doctor's visit? ______________________

Family Physician ______________________

Are you currently under a physician's care? What for? ______________________

Phone Number ______________________

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand that use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

______________________ Patient Signature (Parent if child)

______________ Date

______________________ Dentist Signature