COLUMBUS GROVE FAMILY DENTISTRY

QUALITY CARE FOR ALL AGES

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MEDICAL HISTORY

Dentists are oral health experts. They strive to keep your entire mouth (your teeth and their supportive structures) healthy and disease free. Your mouth is a part of your body, tied to all your other systems. Any health problems that you have, and any medications that you take, are all interrelated. For this reason, we require that you complete the following questionnaire.

Patient's Name:____________________ **Date:**__________

Medical Doctor's Name/Address:____________________

Are you under a Physician's Care Now? ☐-No ☐-Yes, explain:____________________

Have you ever been hospitalized or had a major operation? ☐-No ☐-Yes, explain:____________________

Have you ever had a serious head or neck injury? ☐-No ☐-Yes, explain:____________________

Are you taking any medications, pills or drugs? ☐-No ☐-Yes, explain:____________________

Are you on a special diet? ☐-No ☐-Yes, explain:____________________

Do you use tobacco? ☐-No ☐-Yes, explain:____________________

Do you use controlled substances? ☐-No ☐-Yes, explain:____________________

Have you ever taken Fosamax, Boniva, Actonel or medications containing bisphosphonates? ☐-No ☐-Yes, explain:__________

Women Are you: ☐-Pregnant/Trying to get Pregnant? ☐-Nursing? ☐-Taking Oral Contraceptives?

Are you allergic to any of the following?

☐-Antibiotics Sulfa Drugs/Penicillin/Etc) ☐-Food ☐-Latex ☐-Local Anesthetics ☐-Metals ☐-Pain Killers ☐-Other

List Specifics/Explain Checked Boxes:____________________

Do you have, or have you ever had, any of the following:

☐-AIDS/HIV Positive	☐-Chest Pains	☐-Frequent Headaches	☐-Irregular Heartbeat	☐-Scarlet Fever
☐-Alzheimer's Disease	☐-Cold Sores/Fever Blisters	☐-Genital Herpes	☐-Kidney Problems	☐-Sensory Issues/Autism
☐-Anaphylaxis	☐-Congenital Heart Disorder	☐-Glaucoma	☐-Leukemia	☐-Shingles
☐-Anemia	☐-Convulsions	☐-Hay Fever	☐-Liver Disease	☐-Sickle Cell Disease
☐-Angina	☐-Cortisone Medicine	☐-Heart Attack/Failure	☐-Low Blood Pressure	☐-Sinus Trouble
☐-Arthritis/Gout	☐-Diabetes	☐-Heart Murmur	☐-Lung Disease	☐-Spina Bifida
☐-Artificial Heart Value	☐-Drug Addiction	☐-Heart Pace Maker	☐-Mitral Valve Prolapse	☐-Stomach/Intestinal Disease
☐-Artificial Joint	☐-Easily Winded	☐-Heart Trouble/Disease	☐-Osteoporosis	☐-Stroke
☐-Asthma	☐-Emphysema	☐-Hemophilia	☐-Pain in Jaw Joints	☐-Swelling of Limbs
☐-Blood Disease	☐-Epilepsy or Seizures	☐-Hepatitis A	☐-Parathyroid Disease	☐-Thyroid Disease
☐-Blood Transfusion	☐-Excessive Bleeding	☐-Hepatitis B or C	☐-Psychiatric Care	☐-Tonsillitis
☐-Breathing Problem	☐-Excessive Thirst	☐-Herpes	☐-Radiation Treatments	☐-Tuberculosis
☐-Bruise Easily	☐-Fainting Spells/Dizziness	☐-High Blood Pressure	☐-Recent Weight Loss	☐-Tumors or Growths
☐-Cancer	☐-Frequent Cough	☐-Hives or Rash	☐-Renal Dialysis	☐-Ulcers
☐-Chemotherapy	☐-Frequent Diarrhea	☐-Hypoglycemia	☐-Rheumatic Fever	☐-Venereal Disease
Issues Not Listed Above?	☐-No ☐-Yes, explain:__________		☐-Rheumatism	☐-Yellow Jaundice

Dental History and Symptoms

Reason for today's visit:____________________

Former Dentist Name & Address:____________________

Date of Last Visit:__________

Date of Last Dental X-Ray:__________

Check the Appropriate Box:

Bad Breath	☐-Yes ☐-No
Bleeding Gums	☐-Yes ☐-No
Blisters on Lips/Mouth	☐-Yes ☐-No
Mouth Pain	☐-Yes ☐-No

Burning Sensation on Tongue	☐-Yes ☐-No	Mouth Breathing	☐-Yes ☐-No
Chew on One Side of Mouth	☐-Yes ☐-No	Mouth Pain	☐-Yes ☐-No
Cigarette, Pipe or Cigar Smoking	☐-Yes ☐-No	Orthodontic Treatment	☐-Yes ☐-No
Clicking or Popping Jaw	☐-Yes ☐-No	Pain Around Ear	☐-Yes ☐-No
Dry Mouth	☐-Yes ☐-No	Periodontal/Gum Problems	☐-Yes ☐-No
Fingernail Biting	☐-Yes ☐-No	Sensitivity to Cold	☐-Yes ☐-No
Food Collection Between Teeth	☐-Yes ☐-No	Sensitivity to Heat	☐-Yes ☐-No
Foreign Objects	☐-Yes ☐-No	Sensitivity to Sweets	☐-Yes ☐-No
Grinding Teeth	☐-Yes ☐-No	Sensitivity when Biting	☐-Yes ☐-No
Gums Swollen or Tender	☐-Yes ☐-No	Sores or Growths in Mouth	☐-Yes ☐-No
Jaw Pain or Tiredness	☐-Yes ☐-No	**How Often do You:**	
Lip or Cheek Biting	☐-Yes ☐-No	**Brush?**__________	
Loose Teeth or Broken Fillings	☐-Yes ☐-No	**Floss?**__________	

Signature of Patient, Parent or Guardian:____________________ **Date:**__________