Rena Bains D.D.S. Periodontal & Implant Reconstruction

MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Are you in good health? ☐ Yes ☐ No Height_____ Weight_____ Physician/Doctor Name: _____

Are you under the care of a physician? ☐ No ☐ Yes explain:_____City: _____Phone:_____

Have you had any illness, operation, or been hospitalized in the past five years? ☐ No ☐ Yes explain:_____

Do you have, or have you had, any of the following diseases, medical conditions or procedures?

Y N
- ☐ ☐ Rheumatic fever
- ☐ ☐ Mitral valve prolapse
- ☐ ☐ Heart murmur
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Chest pain/Angina
- ☐ ☐ Heart attack(s) Year_____
- ☐ ☐ Irregular heart beat
- ☐ ☐ Cardiac pacemaker
- ☐ ☐ Heart surgery Year_____
- ☐ ☐ Damaged heart valves
- ☐ ☐ Chronic fatigue/Night sweat
- ☐ ☐ Mental health problems
- ☐ ☐ Bronchitis/Chronic cough
- ☐ ☐ Asthma
- ☐ ☐ Hay fever/ Sinus problems
- ☐ ☐ Snoring/Sleep apnea
- ☐ ☐ Respiratory problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Emphysema

Y N
- ☐ ☐ Blood transfusion
- ☐ ☐ Blood disorder
- ☐ ☐ Bruise easily
- ☐ ☐ A history of drug abuse
- ☐ ☐ Eye disease/Glaucoma
- ☐ ☐ Abnormal bleeding
- ☐ ☐ Bleeding tendency
- ☐ ☐ Problems w/ immune system? (possibly from med. / surg.)
- ☐ ☐ Jaundice / Liver disease
- ☐ ☐ Hepatitis Type:_____
- ☐ ☐ Infectious mononucleosis
- ☐ ☐ Sexually transmitted diseases Type:_____
- ☐ ☐ Thyroid trouble
- ☐ ☐ Gallbladder trouble
- ☐ ☐ Fainting spells
- ☐ ☐ Convulsions/ Epilepsy
- ☐ ☐ Stroke Year_____
- ☐ ☐ Do you use chewing tobacco?
- ☐ ☐ Do you smoke? how much____

Y N
- ☐ ☐ Contact lenses
- ☐ ☐ Diabetes HBA1c Level_____
- ☐ ☐ A history of alcohol abuse
- ☐ ☐ Swollen ankles
- ☐ ☐ Malignant hyperthermia
- ☐ ☐ Low blood sugar
- ☐ ☐ Kidney trouble
- ☐ ☐ Are you on dialysis?
- ☐ ☐ Stomach ulcers
- ☐ ☐ Difficulty climbing 1-2 flights of stairs
- ☐ ☐ Arthritis/Joint disease
- ☐ ☐ Osteoporosis / Osteopenia
- ☐ ☐ Osteonecrosis
- ☐ ☐ Contagious diseases
- ☐ ☐ Delay in healing
- ☐ ☐ Anemia
- ☐ ☐ Tumor or growth
- ☐ ☐ Radiation / Chemotherapy
- ☐ ☐ Replacement Joint Site:_____ Year_____

MEDICATION & ALLERGIES...

Are you now taking or have you taken:

Y N
- ☐ ☐ Blood thinners (Coumadin, Aspirin, Advil)

Y N
- ☐ ☐ Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel): if yes how long?_____

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products)

Are you allergic to or had a reaction to:

Y N
- ☐ ☐ Local anesthetic (numbing med)
- ☐ ☐ Valium or other tranquilizer
- ☐ ☐ Latex
- ☐ ☐ Penicillin / Amoxicillin

Y N
- ☐ ☐ Codeine or other narcotics
- ☐ ☐ Aspirin
- ☐ ☐ Sulfa drugs
- ☐ ☐ Sulfites

Please list any other medication you are allergic to and any other allergies you have:

1-4 below for women only: *(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ☐Yes ☐ No

2) Expected delivery date: _____

3) Are you nursing? ☐Yes ☐ No

4) Are you taking birth control pills: ☐ Yes ☐ No

Continued on next page.....

Rena Bains D.D.S. Periodontal & Implant Reconstruction

DENTAL INFORMATION.....

Reason for today's visit:_____ Are you in pain? □ No □ Yes, for how long? _____

Please indicate any of the following problems by checking off the corresponding box:

□ Removable dental appliance
□ Broken tooth
□ Recent infections
□ Red, swollen gums
□ Bleeding with brushing/ flossing
□ Blisters/sores in or around the mouth
□ My teeth are sensitive to:
□ Hot □ Cold □ Sweets □ Biting

□ Gum disease
□ Bad breath
□ Burning tongue/lips

□ Other Concerns:

How often do you have your teeth cleaned by a dentist or hygienist? _____ When was the last time? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Have you ever had any previous periodontal (gum) treatment? □ Yes □ No

if yes, please indicate below what type of treatment and when.

□ Deep cleanings (root planings) _____ □ Surgery _____ □ Bone grafting _____ □ Tissue grafting _____

Have you ever had complications following dental surgery? □ No □ Yes, please explain:_____

Do you have any anxieties about dental procedures? □ No □ Yes

Have you had difficult dental experiences? □ No □ Yes, □as a child □as an adult

Has there been a lapse in your dental treatment? □No □ Yes, please explain:_____

Has your past dental treatment been: □excellent □good □fair □poor □non-existent

Are you satisfied with your smile? □ No □ Yes

Would you be upset if you lost your teeth? □ No □ Yes

Would you like information on dental implants? □ No □ Yes

For Office Use only: HT:_____ WT:_____ BP:_____ Pulse:_____

To the best of my knowledge the information provided is current and correct. I realize it is important to inform the doctor and her staff of any changes. I acknowledge clinical photography may be taken for case documentation and/or educations purposes.

X_____ **X**_____ **X**_____ **X**_____

Patient's signature (Parent or Guardian if Minor) **Reviewed by** **Rena Bains D.D.S.** **Date**