PARKWOOD
FAMILY DENTAL

Patient Full Name: _____ **Birth Date:** _____

DENTAL HISTORY

Please check the appropriate boxes if you currently have, or have experienced:

□ Tooth sensitivity hot, cold, or sweets
□ Tooth pain when chewing or biting
□ Cracked or Chipped teeth
□ Bleeding gums, How long? _____
□ Pain or soreness in gums
□ Food impaction
□ Unpleasant taste or breath odor
□ Swelling, infection or bumps in mouth
□ Loose teeth
□ Clenching or grinding
□ Jaw joint soreness / pain around the ear area
□ Clicking or popping in the joint when eating
□ Burning tongue
□ Previous orthodontic (braces) treatment
□ Wear a removable dental appliance
□ Mouth breathing or Dry mouth
□ Do you snore?
□ Sleepy throughout the day while working, driving or reading. Persistent tiredness.
□ Have you had a sleep study?
□ Oral habits (nail biting, cheek biting, etc)
□ Dental anxiety
□ Any bad experiences in a dental office?
_____

Dates of Last Dental Exam_____ Gum Disease Screening_____ Oral Cancer Screening_____

What is the primary purpose of today's visit? Any concerns?_____
_____

How important is your dental health to you, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
How would you rate the appearance of your smile, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
If not a 10, please describe what you would want to improve: _____
_____

How often do you brush your teeth? _____
Do you use an Electric Toothbrush? _____
What other dental aids do you use?

□ Floss
□ Mouth rinse, which one _____
□ Water Pik
□ Other_____

Why did you leave your previous dentist?
_____

If you could whiten your teeth for a cost anyone could afford, would you do it? _____

What treatments are you interested in learning about?

□ Orthodontics (braces) or Clear Braces
□ Implants (replacing missing teeth)
□ Dentures or Partial Dentures
□ Sedation (anxiety-free sleep dentistry)
□ Gum Disease Treatments
□ Cosmetic Dentistry or Veneers
□ Teeth Whitening
□ Sleep Apnea treatments
□ Denture Stabilization
□ Headaches or Head/Neck/Jaw Pain

PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU.

1941 S. Ohio Salina, KS 67401
www.ParkwoodFamilyDental.com
785-825-9125

MEDICAL HISTORY

Are you being treated by a physician now? _____ For what?_____
Date of last Physical Exam?_____
Name of Physician_____ Address_____
Physician's Phone_____City _____
My Pharmacy of Choice: _____ Phone # _____
Have you been hospitalized in the last 5 years? For what?_____

HAVE YOU EXPERIENCED:

Yes	No	Chest pain (angina)	Yes	No	Frequent Dizziness
Yes	No	Swollen ankles	Yes	No	Ringing or Pain in ears
Yes	No	Recent weight loss, fever, night sweats	Yes	No	Frequent Headaches
Yes	No	Persistent cough, coughing up blood	Yes	No	Blurred vision
Yes	No	Bleeding problems, bruising easily	Yes	No	Seizures
Yes	No	Sinus problems	Yes	No	Excessive thirst
Yes	No	Difficulty swallowing	Yes	No	Frequent urination
Yes	No	Diarrhea, constipation, blood in stools	Yes	No	Dry mouth
Yes	No	Frequent vomiting or nausea	Yes	No	Jaundice
Yes	No	Difficulty urinating, blood in urine	Yes	No	Joint pain, stiffness, arthritis

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	Heart disease, or attack	Yes	No	Autism, Schizophrenia, psychiatric care
Yes	No	Heart murmur	Yes	No	Tumors or Cancer
Yes	No	Rheumatic fever	Yes	No	Radiation or Chemotherapy treatments
Yes	No	Heart Valve problems	Yes	No	Alzheimers or Dementia
Yes	No	Stroke, Stent or hardening of arteries	Yes	No	Parkinson's or Neuromuscular Diseases
Yes	No	Prosthetic Heart Valve	Yes	No	HIV Positive
Yes	No	High blood pressure	Yes	No	AIDS
Yes	No	High Cholesterol	Yes	No	Eye diseases or glaucoma
Yes	No	Pacemaker	Yes	No	Sleep Apnea
Yes	No	Diabetes	Yes	No	Skin diseases
Yes	No	Asthma	Yes	No	Anemia
Yes	No	Emphysema, COPD, Lung disorders	Yes	No	Venereal Disease
Yes	No	Tuberculosis	Yes	No	Canker Sores or Cold Sore/Fever Blister
Yes	No	Kidney, Bladder or Liver Disease	Yes	No	Hospitalization
Yes	No	Hepatitis A, B, or C	Yes	No	Blood transfusions
Yes	No	Stomach problems, ulcers, colitis	Yes	No	Antibiotic pre-med prior to dental care
Yes	No	Thyroid or Adrenal Disease	Yes	No	Artificial Joint or replacement
Yes	No	Depression, or Anxiety Disorders			

SURGERIES: _____
ALLERGIES to medications, latex, food_____

ARE YOU TAKING?

Yes	No	Tobacco in any form	Yes	No	Do you use Antacids
Yes	No	Alcohol	Yes	No	Consume grapefruit or grapefruit extract
Yes	No	Recreational Drugs			
Yes	No	Bisphosphonates (for Osteoporosis / Bone) such as: Fosomax, Boniva, Actonel, Zometa, or Aredia?			

Please List All Current Medications (prescription, and over-the-counter) and all Supplements_____
_____

WOMEN ONLY:

Yes	No	Are you pregnant or nursing	Yes	No	Taking birth control or hormone pills
Yes	No	Have you had a hysterectomy	Yes	No	Taking fertility drugs

ALL PATIENTS:

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain_____

To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of any changes in my health and/or medication.

PATIENT SIGNATURE:_____DATE:_____