BERRIEN DENTAL PATIENT DENTAL AND MEDICAL INFORMATION

Patient name: _____Date of birth: _____Age:_____ Sex:_____

DENTAL HEALTH HISTORY

Reason for Today's visit:_____ **Date of last visit**:_____

CHECK "YES" OR "NO" TO INDICATE IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

BAD BREATH	☐YES	☐NO	LOOSE TEETH OR BROKEN FILLINGS	☐YES	☐NO
BLEEDING GUMS	☐YES	☐NO	MOUTH BREATHING	☐YES	☐NO
BLISTERS ON LIPS OR MOUTH	☐YES	☐NO	ORTHODONTIC TREATMENT	☐YES	☐NO
BURNING SENSATION ON TONGUE	☐YES	☐NO	PAIN AROUND EAR	☐YES	☐NO
CHEWING TOBACCO	☐YES	☐NO	PERIODONTAL (GUM) TREATMENT	☐YES	☐NO
CIGARETTE, PIPE, OR CIGAR SMOKING	☐YES	☐NO	SENSITIVITY TO COLD	☐YES	☐NO
CLICKING OR POPPING JAW	☐YES	☐NO	SENSITIVITY TO HEAT	☐YES	☐NO
DRY MOUTH	☐YES	☐NO	SENSITIVITY TO SWEETS	☐YES	☐NO
FOOD COLLECTION BETWEEN THE TEETH	☐YES	☐NO	SENSITIVITY TO BITING	☐YES	☐NO
GRINDING TEETH	☐YES	☐NO	SORES OR GROWTHS IN MOUTH	☐YES	☐NO
GUMS SWOLLEN OR TENDER	☐YES	☐NO	MOUTH PAIN UPON BRUSHING	☐YES	☐NO
JAW PAIN OR TIREDNESS	☐YES	☐NO	DENTURES OR PARTIAL DENTURES MADE OVER 5 YEARS AGO	☐YES	☐NO
LIP OR CHEEK BITING	☐YES	☐NO			

HOW OFTEN DO YOU BRUSH? _____ **HOW OFTEN DO YOU FLOSS?** _____

MEDICAL HEALTH HISTORY

CHECK "YES" OR "NO" TO INDICATE IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

HEART PROBLEMS	☐YES	☐NO	BLOOD PROBLEMS	☐YES	☐NO
CHEST PAIN	☐YES	☐NO	EASY BRUISING	☐YES	☐NO
SHORTNESS OF BREATH	☐YES	☐NO	FREQUENT NOSEBLEEDS	☐YES	☐NO
BLOOD PRESSURE PROBLEM **(High/Low)**	☐YES	☐NO	ABNORMAL BLEEDING	☐YES	☐NO
HEART MURMUR	☐YES	☐NO	BLOOD DISEASE (ANEMIA)	☐YES	☐NO
HEART VALVE PROBLEM, (e.g. MVP)	☐YES	☐NO	EVER REQUIRE A BLOOD TRANSFUSION	☐YES	☐NO
SWELLING OF FEET AND ANKLES	☐YES	☐NO			
TAKING HEART MEDICATION	☐YES	☐NO	ALLERGY PROBLEMS	☐YES	☐NO
RHEUMATIC FEVER	☐YES	☐NO	HAY FEVER	☐YES	☐NO
PACEMAKER	☐YES	☐NO	SINUS PROBLEMS	☐YES	☐NO
ARTIFICIAL HEART VALVE	☐YES	☐NO	SKIN RASHES	☐YES	☐NO
CONGENITAL HEART LESIONS	☐YES	☐NO	TAKING ALLERGY MEDICATION	☐YES	☐NO
			ASTHMA	☐YES	☐NO
INTESTINAL PROBLEMS	☐YES	☐NO			
ULCERS	☐YES	☐NO	BONE OR JOINT PROBLEMS	☐YES	☐NO
UNEXPLAINED WEIGHT LOSS OR GAIN	☐YES	☐NO	ARTHRITIS/RHEUMATISM	☐YES	☐NO
SPECIAL DIET	☐YES	☐NO	BACK OR NECK PAIN	☐YES	☐NO
CONSTIPATION/DIARRHEA	☐YES	☐NO	JOINT REPLACEMENT (e.g., total hip, knee, pins, or implants)	☐YES	☐NO
KIDNEY OR BLADDER PROBLEMS	☐YES	☐NO			
KIDNEY DISEASE	☐YES	☐NO	**PREMEDICATION REQUIRED BY PHYSICIAN**	☐YES	☐NO
			TUBERCULOSIS OR RESPIRATORY DISEASE	☐YES	☐NO
FAINTING SPELLS, SEIZURES, OR EPILEPSY	☐YES	☐NO	EMPHYSEMA	☐YES	☐NO
STROKE(S)	☐YES	☐NO	DO YOU SMOKE?	☐YES	☐NO
FREQUENT OR SEVERE HEADACHES	☐YES	☐NO	If so, how much? _____		
HISTORY OF HEAD INJURY	☐YES	☐NO			
THYROID PROBLEMS	☐YES	☐NO	DO YOU CONSUME ALCOHOL?	☐YES	☐NO
			If so, how much? _____		
PERSISTENT COUGH OR SWOLLEN GLANDS	☐YES	☐NO			
TONSILLITIS	☐YES	☐NO	HISTORY OF ALCOHOL OR DRUG ABUSE?	☐YES	☐NO
CANCER/TUMOR	☐YES	☐NO	HEPATITIS (type _____?)	☐YES	☐NO
HISTORY OF CHEMOTHERAPY/RADIATION	☐YES	☐NO	JAUNDICE OR LIVER TROUBLE	☐YES	☐NO
			HERPES OR OTHER STD	☐YES	☐NO
DIABETES	☐YES	☐NO	HIV –positive/AIDS	☐YES	☐NO
URINATE MORE THAN 6 TIMES A DAY	☐YES	☐NO	GLAUCOMA	☐YES	☐NO
THIRSTY OR DRY MOUTH MUCH OF THE TIME	☐YES	☐NO	DO YOU WEAR CONTACT LENSES?	☐YES	☐NO
FAMILY HISTORY OF DIABETES	☐YES	☐NO	HISTORY OF MENTAL DISORDERS	☐YES	☐NO
PHYSICAL DISABILITIES	☐YES	☐NO			

CONTINUED ON OTHER SIDE

ARE YOU ALLERGIC, OR HAVE YOU REACTED ADVERSELY, TO ANY OF THE FOLLOWING?

LOCAL ANESTHETICS ("NOVACAINE")	☐YES	☐NO
PENICILLIN OR OTHER ANTIBIOTICS	☐YES	☐NO
SULFA DRUGS	☐YES	☐NO
ASPIRIN, ACETAMINOPHEN, OR IBUPROFEN	☐YES	☐NO
CODEINE, DEMEROL, OR OTHER NARCOTICS	☐YES	☐NO
BARBITURATES, SEDATIVES, SLEEPING PILLS	☐YES	☐NO
REACTION TO METALS	☐YES	☐NO
LATEX OR RUBBER DAM	☐YES	☐NO

OTHER _____

_____

DURING THE PAST 12 MONTHS, HAVE YOU TAKEN ANY OF FOLLOWING?

ANTIBIOTICS OR SULFA DRUGS	☐YES	☐NO
ANTICOAGULANTS (e.g., COUMADIN)	☐YES	☐NO
HIGH BLOOD PRESSURE MEDICINE	☐YES	☐NO
INSULIN, ORINASE, OR SIMILAR DRUG	☐YES	☐NO
ASPIRIN	☐YES	☐NO
NONPRESCRIPTION DRUG/SUPPLEMENTS	☐YES	☐NO
ORAL BISPHOSPHONATES, (e.g. Fosamax, Boniva, Actonel, Aredia, Reclast, Skelid, Zometa, etc.)	☐YES	☐NO

OTHER _____

_____

WOMEN:

ARE YOU TAKING CONTRACEPTIVES OR OTHER HORMONES?	☐YES	☐NO
ARE YOU PREGNANT?	☐YES	☐NO
If so, expected delivery date: _____		
ARE YOU NURSING?	☐YES	☐NO
HAVE YOU REACHED MENOPAUSE?	☐YES	☐NO
If so, do you have any symptoms? _ _____		

1)	DO YOU FEEL TIRED AFTER A FULL NIGHTS REST?	☐YES	☐NO
2)	DO YOU, OR HAS ANYONE TOLD YOU THAT YOU SNORE?	☐YES	☐NO
3)	HAVE YOU EVER WOKEN UP IN THE MIDDLE OF THE NIGHT CHOKING/GASPING FOR AIR?	☐YES	☐NO
4)	DO YOU WEAR, OR HAVE YOU BEEN PRESCRIBED A CPAP?	☐YES	☐NO

DO YOU HAVE ANY OTHER CONDITIONS NOT LISTED? ☐YES ☐NO

If so, explain:_____

_____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY **DATE**

REVIEWED BY: _____ _____

DATE