Kennebunk
Center for Dentistry
Kindness. Compassion. Dedication

Patient Name: _____ DOB: _____ Today's Date: _____

**Dental History**

Do you have a specific problem? _____ Describe: _____
Date of last dental visit: _____ Were X-rays taken? _____ Do you brush and floss daily? _____

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Have you ever been treated for gum disease? | ☐ | ☐ | Do you have jaw discomfort? |
| ☐ | ☐ | Do you have any sensitive teeth? | ☐ | ☐ | Are you aware of a clicking jaw or grinding or clenching teeth? |
| ☐ | ☐ | Do you have any loose teeth? | | | |
| ☐ | ☐ | Do you have any broken fillings? | ☐ | ☐ | Do you snore? |
| ☐ | ☐ | Have you ever worn braces? | ☐ | ☐ | Do you experience significant daily drowsiness? |
| ☐ | ☐ | Do you like your smile? | | | |
| ☐ | ☐ | Would you like your smile to be different? | ☐ | ☐ | Do you suffer from migraines? |
| ☐ | ☐ | Would you like a whiter smile? | ☐ | ☐ | Do you get frequent headaches? |
| ☐ | ☐ | Do you have any teeth that bother you? | ☐ | ☐ | Are you apprehensive about treatment? |

**Medical History**

Physician's Name: _____ Phone #: _____ City: _____
Do you have any current health problems? _____ Please indicate: _____
How would you describe your present health? _____
**CURRENT MEDICATIONS:** _____
**MEDICATION ALLEGIES:** _____ **LATEX ALLERGY?** ☐Y ☐N

Do you now or have you ever had any of the following? Please check and describe.

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Heart trouble _____ | ☐ | ☐ | Artificial heart valve _____ |
| ☐ | ☐ | Heart attack _____ | ☐ | ☐ | Artificial joint _____ |
| ☐ | ☐ | Mitral valve prolapse _____ | ☐ | ☐ | Heart murmur _____ |
| ☐ | ☐ | Rheumatic fever _____ | ☐ | ☐ | Pacemaker/defibrillator _____ |

Are you currently taking <u>or have you ever taken</u>:

| Yes | No | Yes | No | Yes | No | Yes | No |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ Coumadin or blood thinners | ☐ | ☐ Daily aspirin | ☐ | ☐ Actonel | ☐ | ☐ Boniva |
| | | ☐ | ☐ Fosamax | ☐ | ☐ Zometa | ☐ | ☐ Aredia |

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Have you ever had any of the following:

| Yes | No | Yes | No | Yes | No |
|---|---|---|---|---|---|
| ☐ | ☐ Low/high blood pressure | ☐ | ☐ Parkinson's disease | ☐ | ☐ Retinal surgery |
| ☐ | ☐ Stroke | ☐ | ☐ Hepatitis A, B, or C | ☐ | ☐ Sinus problems |
| ☐ | ☐ Lung disease | ☐ | ☐ Kidney problems | ☐ | ☐ Bleeding problems |
| ☐ | ☐ Breathi ng problems | ☐ | ☐ Dialysis | ☐ | ☐ Allergies |
| ☐ | ☐ Asthma | ☐ | ☐ Thyroid disease | ☐ | ☐ Alzheimer's disease |
| ☐ | ☐ Tuberculosis | ☐ | ☐ Rheumatism | ☐ | ☐ Epilepsy or seizures |
| ☐ | ☐ Cancer | ☐ | ☐ Arthritis | ☐ | ☐ Sleep apnea |
| ☐ | ☐ Chemotherapy | ☐ | ☐ Fibromyalgia | ☐ | ☐ CPAP use |
| ☐ | ☐ Radiation | ☐ | ☐ Herpes | ☐ | ☐ Liver disease |
| ☐ | ☐ Smoking/tobacco use | ☐ | ☐ HIV-positive/AIDS | ☐ | ☐ Diabetes |
| | | ☐ | ☐ Addiction/alcoholism | ☐ | ☐ Women: pregnant/nursing |

To the best of my knowledge, all the preceding answers are correct. _____
Patient's signature

Reviewed by: _____ Date: _____

Medical Updates: I have reviewed my Medical History and confirm that it adequately states past and present conditions.

| Date | Changes | Patient's Signature | Reviewed By |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |