Kennebunk
Center for Dentistry
Kindness. Compassion. Dedication.

Patient Name: _____ Date of Birth: _____

Patient Dental History

Do you have a specific problem? _____ Please 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 snore?
☐	☐	Do you have any broken fillings?	☐	☐	Do you experience significant daily drowsiness?
☐	☐	Have you ever worn braces?	☐	☐	Do you suffer from migraines?
☐	☐	Do you like to smile?	☐	☐	Do you get frequent headaches?
☐	☐	Would you like your smile to be different?	☐	☐	Are you apprehensive about treatment?
☐	☐	Would you like a whiter smile?			
☐	☐	Do you have any teeth that bother you?			

Patient Medical History

Physician's Name: _____ Phone Number _____ City: _____

Do currently have any health problems? Please Indicate: _____

_____

How would you describe your present health? _____

CURRENT MEDICATIONS: _____

MEDICATION ALLERGIES: _____ LATEX ALLERGY? ☐ Y ☐ N

OTHER ALLERGIES: _____

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

Yes	No		
☐	☐	Heart trouble	_____
☐	☐	Heart attack	_____
☐	☐	Mitral valve prolapse	_____
☐	☐	Rheumatic fever	_____
☐	☐	Artificial heart valve	_____
☐	☐	Artificial joint	_____
☐	☐	Heart murmur	_____
☐	☐	Pacemaker/defibrillator	_____
☐	☐	Do you require a pre-medication?	_____

Kennebunk Center for Dentistry • 2 Livewell Dr Suite 105, Kennebunk, ME
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Patient Medical History, continued...

Are you currently taking, or have you ever taken:

Yes	No	
☐	☐	Coumadin or blood thinners
☐	☐	Daily asprin
☐	☐	Fosamax
☐	☐	Actonel
☐	☐	Zometa
☐	☐	Boniva
☐	☐	Aredia

Have you ever had any of the following?

Yes	No	*If "yes" please circle one:*
☐	☐	Low/high blood pressure
☐	☐	Stroke
☐	☐	Lung Disease
☐	☐	Breathing problems
☐	☐	Asthma
☐	☐	Tuberculosis
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Radiation
☐	☐	Smoking/tobacco use

Yes	No	
☐	☐	Parkinson's disease
☐	☐	Hepatitis A, B, or C
☐	☐	Kidney problems
☐	☐	Dialysis
☐	☐	Thyroid disease
☐	☐	Rheumatism
☐	☐	Arthritis
☐	☐	Fibromyalgia
☐	☐	Herpes
☐	☐	HIV-positive/AIDS
☐	☐	Addiction/alcoholism

Yes	No	
☐	☐	Retinal surgery
☐	☐	Sinus problems
☐	☐	Bleeding problems
☐	☐	Allergies
☐	☐	Alzheimer's disease
☐	☐	Epilepsy or seizures
☐	☐	Sleep apnea
☐	☐	CPAP use
☐	☐	Liver disease
☐	☐	Diabetes
☐	☐	Women: pregnant/nursing

To the best of my knowledge, all of the preceding answers are correct.

PATIENT'S SIGNATURE _____ Date _____

Reviewed by: _____ Date: _____

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

Date	Changes	Patient Signature	Reviewed By

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