FGC

Date of Birth _____

Home Phone _____

Name (Mr. Ms. Mrs. Dr.) _____ Cell Phone _____

Address _____ Business Phone _____
(Street)

_____ Email _____
(City) (State) (Zip)

Referred by _____ SS# _____
(Name & Phone Number)

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Approximate date of last physical exam _____

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. any "allergic" reaction to:		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulpha		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) (i.e. hip, knee, shoulder)	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR>3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c=_____) _____	☐	☐

	YES	NO
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e.. taking bisphosphonates) _____	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin, rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness(es) _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen) _____	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. FEMALE - taking birth control pills _____	☐	☐
54. FEMALE - pregnant _____	☐	☐
55. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Patient's Name _____

List current medications, supplements, and or vitamins

Drug	Purpose	Drug	Purpose
1.		7.	
2.		8.	
3.		9.	
4.		10	
5.		11.	
6.		12.	

Ask for an additional sheet if you are taking more than 12 medications

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS ADVANCE NOTICE

Please refer to our 24 hour answering service for after hours communications.

DENTAL HISTORY

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING:

PERSONAL DENTAL HISTORY	YES	NO
1. Have you ever had complications from past dental treatment?	☐	☐
2. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
3. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
4. Have you had any teeth removed?	☐	☐
SMILE CHARACTERISTICS		
5. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
6. Have you ever whitened (bleached your teeth)?	☐	☐
7. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
8. Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT		
9. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
10. Do you / would you have any problems chewing gum?	☐	☐
11. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods?	☐	☐
12. Are your teeth crowding or developing spaces?	☐	☐
13. Do you chew ice or have any other oral habits?	☐	☐
14. Do you clench our teeth in the daytime or make them sore?	☐	☐
15. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
GUM AND BONE		
16. Do your gums bleed when brushing or flossing?	☐	☐
17. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
18. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
19. Is there anyone with a history of periodontal disease in your family?	☐	☐
20. Have you ever experienced gum recession?	☐	☐
21. Have you ever had any teeth become loose on their own (without an injury) or do you have difficulty eating apples?	☐	☐
22. Have you experienced a burning sensation in your mouth?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____