Cromwell Dental Care Inc

Medical History (2020)

Patient Name: Birth Date: Date Created:

Medical History

Who is your Primary Care Physician?		Comment	
Date of Last Visit?			
Have you had any serious medical issues/operations? Please Explain	◯ Yes ◯ No	If yes	
Have you ever taken medications containing bisphosphinates? (Ex: Actonel, Boniva, Fosamax)	◯ Yes ◯ No	If yes	
Do you use tobacco/vaping products? If so, what type, how much, and for how long?	◯ Yes ◯ No	If yes	

Mark if you have had any of the following. If marked please explain in the comment section below

☐ Angina/Chest Pains	☐ Cortisone Treatments	☐ Hepatitis B	☐ Shortness of Breath
☐ Arthritis	☐ Cough, Persistent	☐ Hepatitis C	☐ Skin Rash
☐ Artificial Heart Valve	☐ Diabetes	☐ High Blood Pressure	☐ Stroke
☐ Artificial Joint	☐ Epilepsy/Siezures	☐ HIV/Aids	☐ Swelling of Fee/Ankles
☐ Asthma	☐ Fainting	☐ Jaw Pain	☐ Thyroid Problems
☐ Back/Neck Proplems	☐ Glaucoma	☐ Kidney Disease	☐ Tonsillitis
☐ Blood Diseases	☐ Headaches	☐ Liver Disease	☐ Tuberculosis, Currently
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Ulcer
☐ Chemical Dependency	☐ Heart Conditions, Other	☐ Radiation Treatment	☐ Venereal Disease
☐ Chemotherapy	☐ Hemophilia	☐ Respiratory Disease	☐ Other

Comments

Please List all medications that you are currently taking (including OTC medications) -- If you have a Medication List we will scan this into your chart.

If Applicable, mark all that apply

☐ Currently Pregnant - If Yes, expected due date? ☐ Nursing ☐ Taking oral contraceptives

Allergies

☐ Aspirin	☐ Penicillin	☐ Sulfa Drugs	☐ Codeine
☐ Latex	☐ Local Anesthetics	☐ Other	☐ None

Please explain type of reaction Comment

See Reverse Side

Dental History

Reason fortoday's visit		Comment	
Previous Dentist		Comment	
Date of last dental exam			
Date of last dental X-rays			

Mark if you have had any of the following

☐ Bad Breath	☐ Loose Teeth	☐ Clicking/Popping Jaw	☐ Cold Sensitivity
☐ Bleeding Gums	☐ Periodontal Treatment	☐ Grinding/Clenching Teeth	☐ Hot Sensitivity
☐ Food Collection Between Teeth	☐ Missing Teeth	☐ Sores/Growths inyour mouth	☐ Sensitivity whenbiting

How would you grade your current dental health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you grade your smile?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you interested in getting more information on any of the following?

☐ Whitening	☐ Straightening your smile	☐ Cosemetic Dentistry	☐ Sleep Apnea
☐ Implants	☐ Athletic Mouthguards	☐ Wisdom Teeth Removal	

How often do you floss? (Mark the one that describes your habits the best)

☐ Every Day of the Week ☐ Few times a Week ☐ Every other Week ☐ Never

☐ Other:

How often do you brush? (Mark the one that describes your habits the best)

☐ Twice Daily ☐ Once Daily ☐ Occasionally ☐ Never

☐ Other:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my resposibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____