

Fairlawn Family Dentistry, 1813 SW Fairlawn Rd, Topeka, KS 66604 785-272-9443

Patient name: _____

BirthDate: _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Check (✓) if you have or have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss _____ How often do you brush? _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering following questions.

Physician's name: _____ Date of last dental care: _____

Are you under a physician's care now? Yes No

If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No

Have you ever had a serious head or neck injury? Yes No

Are you taking any medications, pills, or drugs? Yes No

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you pregnant? Yes No

Nursing? Yes No

Taking birth control pills? Yes No

Check (✓) if you have or have had problems with any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cold Sores/Fever blisters | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Congenital Heart | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Lesions Treatments | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy Fainting | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors or growths |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stomach/Intestinal disease |
| <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Recent Weight loss | <input type="checkbox"/> Parathyroid | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Emphysema | | <input type="checkbox"/> Drug addiction | |

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Have you ever had any serious illness not listed above? YES NO If yes, please explain

List medications you are currently taking:

Allergies:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient