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:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collecting between the teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ 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:

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

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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:

☐ Aspirin	☐ Local Anesthetic	☐ Iodine	☐ Other _____
☐ Barbiturates (Sleeping Pills)	☐ Penicillin	☐ Latex	_____
☐ Codeine	☐ Sulfa	☐ 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