Wagner Family Dentistry

Patient Name:_____

Date:_____

Please check the appropriate box if you have had any of the following:

- ☐ Alcoholism/Drug
- ☐ Artificial Joints/Prosthetic
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Trouble of any kind
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ High/Low Blood Pressure
- ☐ HIV Positive/AIDS
- ☐ Kidney Problems
- ☐ Mitral Valve Prolapse
- ☐ Organ Transplant
- ☐ Prosthetic Cardiac Valves
- ☐ Prostate Disorders
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures or Convulsions
- ☐ Stroke
- ☐ Syncope/Tendency to Faint
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Dental History

Why are you now seeking dental treatment? _____

Name of previous Dentist & Date of last dental exam: _____

Major dental work done in the past: _____

Reason for leaving previous dentist: _____

Are you satisfied with your past dentistry? ☐ Yes ☐ No

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

Do you brush and floss daily? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

Does food wedge between your teeth? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you hear popping or clicking, or feel pain around your ears while chewing? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Do you have swelling, lumps, or sore sports in your mouth? ☐ Yes ☐ No

Do you have difficulty opening wide? ☐ Yes ☐ No

Do sweets, cold, heat, or chewing cause pain? ☐ Yes ☐ No

Do you have a fear of having dentistry done? ☐ Yes ☐ No

Are you available for appointments on short notices? ☐ Yes ☐ No

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Patient Name:_____

Date:_____

Name of General Physician:_____

Phone:_____ Date of last examination_____

Have you had surgery or X-ray treatment for a tumor, growth, or other condition of the head, mouth or lips?_____ ___Yes ___No

Have you ever had any serious illness or major operations? ___Yes ___No

Are you being treated for any medical conditions? ___Yes ___No

If yes, please list:_____

_____

Are you taking any medications regularly? (Prescription or over the counter) ___Yes ___No

If yes, please List:

Drug:_____Drug:_____Drug:_____

Drug:_____Drug:_____Drug:_____

Have you had an adverse reaction or allergy to any of the following?

Aspirin---------- ___Yes ___No

Dental Anesthetics or Nitrous---------- ___Yes ___No

Anti-inflammatory Medications---------- ___Yes ___No

Penicillin or other Antibiotics---------- ___Yes ___No

Codeine or other pain medications---------- ___Yes ___No

Latex Materials---------- ___Yes ___No

Other_____

If yes, please list:_____

Are you currently taking or have taken in the past, any of the Bisphosphonate family of drugs?

(Fosamax, Boniva, Aredia, Actonel, Zometa or others)---------- ___Yes ___No

Have you ever had abnormal bleeding or difficulty with clotting after a wound? ___Yes ___No

Do you smoke? If yes, how much?_____ ___Yes ___No

Are you taking female hormones (oral contraceptives, etc?)---------- ___Yes ___No

Are you pregnant or nursing at the present time?---------- ___Yes ___No