WELLSVILLE FAMILY DENTAL

**Patient Full Name: _____ Birth Date: _____**

**DENTAL HISTORY**

*Please check the appropriate boxes if you currently have, or have experienced:*

□ Tooth sensitivity hot, cold, or sweets
□ Tooth pain when chewing or biting
□ Cracked or Chipped teeth
□ Bleeding gums, How long? _____
□ Pain or soreness in gums
□ Food impaction
□ Unpleasant taste or breath odor
□ Swelling, infection or bumps in mouth
□ Loose teeth
□ Clenching or grinding
□ Jaw joint soreness / pain around the ear area
□ Clicking or popping in the joint when eating
□ Burning tongue
□ Previous orthodontic (braces) treatment
□ Wear a removable dental appliance
□ Mouth breathing or Dry mouth
□ Do you snore?
□ Sleepy throughout the day while working, driving or reading. Persistent tiredness.
□ Have you had a sleep study?
□ Oral habits (nail biting, cheek biting, etc)
□ Dental anxiety
□ Any bad experiences in a dental office?
_____

Dates of Last Dental Exam_____ Gum Disease Screening_____ Oral Cancer Screening_____

What is the primary purpose of today's visit? Any concerns?_____
_____

How important is your dental health to you, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
How would you rate the appearance of your smile, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
If not a 10, please describe what you would want to improve: _____
_____

How often do you brush your teeth? _____
Do you use an Electric Toothbrush? _____
What other dental aids do you use?

□ Floss
□ Mouth rinse, which one _____
□ Water Pik
□ Other_____

Why did you leave your previous dentist?
_____

If you could whiten your teeth for a cost anyone could afford, would you do it? _____

What treatments are you interested in learning about?

□ Orthodontics (braces) or Clear Braces
□ Implants (replacing missing teeth)
□ Dentures or Partial Dentures
□ Sedation (anxiety-free sleep dentistry)
□ Gum Disease Treatments
□ Cosmetic Dentistry or Veneers
□ Teeth Whitening
□ Sleep Apnea treatments
□ Denture Stabilization
□ Headaches or Head/Neck/Jaw Pain

**PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU.**

501 Main St Wellsville, KS 66092
www.WellsvilleFamilyDental.com
785-883-2222

**MEDICAL HISTORY**

Are you being treated by a physician now? _____ For what?_____
Date of last Physical Exam?_____
Name of Physician_____ Address_____
Physician's Phone_____City _____
My Pharmacy of Choice: _____ Phone # _____
Have you been hospitalized in the last 5 years? For what?_____

**HAVE YOU EXPERIENCED:**

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | Chest pain (angina) | Yes | No | Frequent Dizziness |
| Yes | No | Swollen ankles | Yes | No | Ringing or Pain in ears |
| Yes | No | Recent weight loss, fever, night sweats | Yes | No | Frequent Headaches |
| Yes | No | Persistent cough, coughing up blood | Yes | No | Blurred vision |
| Yes | No | Bleeding problems, bruising easily | Yes | No | Seizures |
| Yes | No | Sinus problems | Yes | No | Excessive thirst |
| Yes | No | Difficulty swallowing | Yes | No | Frequent urination |
| Yes | No | Diarrhea, constipation, blood in stools | Yes | No | Dry mouth |
| Yes | No | Frequent vomiting or nausea | Yes | No | Jaundice |
| Yes | No | Difficulty urinating, blood in urine | Yes | No | Joint pain, stiffness, arthritis |

**DO YOU HAVE OR HAVE YOU HAD:**

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | Heart disease, or attack | Yes | No | Autism, Schizophrenia, psychiatric care |
| Yes | No | Heart murmur | Yes | No | Tumors or Cancer |
| Yes | No | Rheumatic fever | Yes | No | Radiation or Chemotherapy treatments |
| Yes | No | Heart Valve problems | Yes | No | Alzheimers or Dementia |
| Yes | No | Stroke, Stent or hardening of arteries | Yes | No | Parkinson's or Neuromuscular Diseases |
| Yes | No | Prosthetic Heart Valve | Yes | No | HIV Positive |
| Yes | No | High blood pressure | Yes | No | AIDS |
| Yes | No | High Cholesterol | Yes | No | Eye diseases or glaucoma |
| Yes | No | Pacemaker | Yes | No | Sleep Apnea |
| Yes | No | Diabetes | Yes | No | Skin diseases |
| Yes | No | Asthma | Yes | No | Anemia |
| Yes | No | Emphysema, COPD, Lung disorders | Yes | No | Venereal Disease |
| Yes | No | Tuberculosis | Yes | No | Canker Sores or Cold Sore/Fever Blister |
| Yes | No | Kidney, Bladder or Liver Disease | Yes | No | Hospitalization |
| Yes | No | Hepatitis A, B, or C | Yes | No | Blood transfusions |
| Yes | No | Stomach problems, ulcers, colitis | Yes | No | Antibiotic pre-med prior to dental care |
| Yes | No | Thyroid or Adrenal Disease | Yes | No | Artificial Joint or replacement |
| Yes | No | Depression, or Anxiety Disorders | | | |

**SURGERIES:** _____

**ALLERGIES** to medications, latex, food_____

**ARE YOU TAKING?**

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | Tobacco in any form | Yes | No | Do you use Antacids |
| Yes | No | Alcohol | Yes | No | Consume grapefruit or grapefruit extract |
| Yes | No | Recreational Drugs | | | |
| Yes | No | Bisphosphonates (for Osteoporosis / Bone) such as: Fosomax, Boniva, Actonel, Zometa, or Aredia? | | | |

Please List All Current Medications (prescription, and over-the-counter) and all Supplements_____
_____

**WOMEN ONLY:**

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | Are you pregnant or nursing | Yes | No | Taking birth control or hormone pills |
| Yes | No | Have you had a hysterectomy | Yes | No | Taking fertility drugs |

**ALL PATIENTS:**

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain_____

*To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of any changes in my health and/or medication.*

PATIENT SIGNATURE:_____DATE:_____