MEDICAL HISTORY

Title _____ Patient Name_____ Nick Name _____ DOB _____
Address _____
Home phone _____ Mobile _____ Email address _____
Emergency contact name _____ Emergency contact number _____ Relationship _____
Name of GP _____ GP telephone number _____
Most recent physical exam _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Private health insurance name _____ Ref no. _____ Medicare Number _____ Ref no.____
How did you find out about Riverside Dental? _____

DO YOU HAVE or HAVE YOU EVER HAD: **YES/NO**

1. hospitalization for illness or injury _____ ☐ ☐
2. an allergic reaction to ☐ ☐
   - ☐ Aspirin, ibuprofen, acetaminophen, codeine
   - ☐ Penicillin
   - ☐ Erythromycin
   - ☐ Tetracycline
   - ☐ Sulfa
   - ☐ Local anaethetic
   - ☐ Fluoride
   - ☐ Metals (nickel, gold, silver, _____)
   - ☐ Latex
   - ☐ Other _____
3. heart problems, or cardiac stent within last six months _____ ☐ ☐
4. history of infective endocarditis _____ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) _____ ☐ ☐
6. pacemaker or implantable defibrillator _____ ☐ ☐
7. orthopedic implant (joint replacement) _____ ☐ ☐
8. rheumatic or scarlet fever _____ ☐ ☐
9. high or low blood pressure _____ ☐ ☐
10. a stroke (taking blood thinners) _____ ☐ ☐
11. anaemia or blood disorder _____ ☐ ☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____ ☐ ☐
13. emphysema, shortness of breath, sarcoidosis _____ ☐ ☐
14. tuberculosis, measles, chicken pox _____ ☐ ☐
15. asthma _____ ☐ ☐
16. breathing or sleeping problems (i.e. sleep apnea, snoring, sinus) ☐ ☐
17. kidney disease _____ ☐ ☐
18. liver disease _____ ☐ ☐
19. Jaundice _____ ☐ ☐
20. thyroid, parathyroid, or calcium deficiency _____ ☐ ☐
21. hormone deficiency _____ ☐ ☐
22. high cholesterol or taking statin drugs _____ ☐ ☐
23. diabetes (HbA1c= _____) _____ ☐ ☐
24. stomach or duodenal ulcer _____ ☐ ☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____ ☐ ☐
26. osteoporosis/osteopenia (i.e. taking bisphophonates ☐ ☐
27. arthritis _____ ☐ ☐
28. autoimmune disease ☐ ☐
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma _____ ☐ ☐
30. contact lenses _____ ☐ ☐
31. head or neck injuries _____ ☐ ☐
32. epilepsy, convulsions (seizures) _____ ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) _____ ☐ ☐
34. viral infections and cold sores _____ ☐ ☐
35. any lumps or swelling in mouth _____ ☐ ☐
36. hives, skin rash, hay fever _____ ☐ ☐
37. STI / STD / HPV _____ ☐ ☐
38. hepatitis (type ___) _____ ☐ ☐
39. HIV/AIDS _____ ☐ ☐
40. tumor, abnormal growth _____ ☐ ☐
41. radiation therapy _____ ☐ ☐
42. chemotherapy, immunosuppressive medication _____ ☐ ☐
43. emotional difficulties _____ ☐ ☐
44. psychiatric treatment _____ ☐ ☐
45. antidepressant medication _____ ☐ ☐
46. alcohol / recreational drug use _____ ☐ ☐

ARE YOU:

47. Presently being treated for any other illness _____ ☐ ☐
48. Aware of a change in your health in the last 24 hours __ ☐ ☐
    (i.e. fever, chills, new cough, diarrhea)
49. Taking medication for weight management _____ ☐ ☐
50. Taking dietary supplements _____ ☐ ☐
51. Often exhausted or fatigued _____ ☐ ☐
52. Experiencing frequent headaches _____ ☐ ☐
53. A smoker, smoked previously or use smokeless tobacco_ ☐ ☐
54. Considered a touchy/sensitive person _____ ☐ ☐
55. Often unhappy or depressed _____ ☐ ☐
56. FEMALE – taking birth control pills _____ ☐ ☐
57. FEMALE – pregnant _____ ☐ ☐
58. MALE – prostate disorders _____ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient/Guardian's Signature: _____ Date: _____

Doctor's Signature _____ Date: _____

ASA _____ (1-6)

DENTAL HISTORY

Name_____ Nick Name _____ DOB_____
Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous dentist _____ How long have you been a patient? _____Months/Years
Date of most recent dental exam ___/___/___ Date of most recent x-rays ___/___/___
Date of most recent treatment (other than cleaning) ___/___/___
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2. Have you ever had an unfavourable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anaesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning sensation in your mouth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
25. Are your teeth becoming more crooked, crowded or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____	☐	☐
28. Do you place your tongue between your teeth or rest your teeth against your tongue? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with headache or an awareness of your teeth? _____	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
34. Have you ever whitened (bleached) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient/Guardians's Signature: _____ Date: _____

Doctor's Signature _____ Date: _____