John M Schiefelbein, DMD, PLLC

PATIENT NAME: _____ **BIRTHDATE:** _____

DENTAL HISTORY

Chief dental concern: _____

Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

Have you ever had any serious trouble associated with any dental experience: ❑Yes ❑No
If yes, please explain: _____

Are you happy with the appearance of your teeth? ❑Yes ❑No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Frequent headaches	❑Yes ❑No	Orthodontic treatment	❑Yes ❑No
Dry mouth	❑Yes ❑No	Tooth sensitive to chewing	❑Yes ❑No
Pain in jaw	❑Yes ❑No	Unpleasant taste or bad breath	❑Yes ❑No
Clicking/popping in jaw	❑Yes ❑No	Periodontal/gum disease	❑Yes ❑No
Clenching or grinding	❑Yes ❑No		

MEDICAL HISTORY

Are you under a physician's care for a <u>current</u> illness? ❑Y ❑N Name: _____
If yes, please explain: _____

Primary Care Physician: _____ Clinic: _____

Have you been hospitalized or had a major operation within the past 5 years?
If yes, please explain: _____

Have you ever had a serious head or neck injury? Please explain: _____

Have you been told to pre-medicate with antibiotics before dental treatment?
If yes, please explain: _____

Have you been prescribed Aspirin, Coumadin, Plavix or any other blood thinning medications? ❑Yes ❑No

Do you use tobacco, smoke, vape or use marijuana? What type:_____ How often:_____

MEDICATIONS: Please list all medications you are currently taking:

Name of medication	Dosage	Condition/Reason for medication

ALLERGIES: Are you allergic to any of the following:
❑Penicillin ❑Other Antibiotics ❑ Codeine ❑Latex ❑ Metal ❑ Local Anesthetics

Other – If yes, please explain: _____

Please continue to 2nd page

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Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Artificial Joint Date: _____	❑Yes ❑No	Asthma	❑Yes ❑No
Cancer-Malignancy Date: _____	❑Yes ❑No	COPD/Emphysema	❑Yes ❑No
Joint Infection	❑Yes ❑No	Tuberculosis or Frequent Cough	❑Yes ❑No
Hemophilia	❑Yes ❑No	Anemia or other Blood Disorder	❑Yes ❑No
Diabetes	❑Yes ❑No	Excessive bleeding or bruising	❑Yes ❑No
Autoimmune disease (i.e. rheumatoid arthritis, lupus)	❑Yes ❑No	Hepatitis (Type _____)	❑Yes ❑No
Drug or Radiation-induced Immunosuppress	❑Yes ❑No	Liver Disease / Jaundice	❑Yes ❑No
AIDS/HIV Positive	❑Yes ❑No	Kidney Disease	❑Yes ❑No
Infective Endocarditis	❑Yes ❑No	Thyroid Disease	❑Yes ❑No
Cardiac Transplant	❑Yes ❑No	Cold Sores	❑Yes ❑No
Congenital Heart Disease	❑Yes ❑No	Glaucoma/Retinal surgery	❑Yes ❑No
Artificial Heart Valve	❑Yes ❑No	Osteoporosis	❑Yes ❑No
Heart Disease/Attack Date: _____	❑Yes ❑No	Arthritis	❑Yes ❑No
Pacemaker Date Placed: _____	❑Yes ❑No	Epilepsy or Seizures	❑Yes ❑No
Angina	❑Yes ❑No	Neurological Disorder	❑Yes ❑No
Heart Murmur/Rheumatic Fever	❑Yes ❑No	Fainting/Dizziness	❑Yes ❑No
Stroke Date: _____	❑Yes ❑No	Sinus Problems/Hay Fever	❑Yes ❑No
High / Low Blood Pressure (Circle one)	❑Yes ❑No	Psychiatric Care	❑Yes ❑No
High Cholesterol	❑Yes ❑No	Drug/Alcohol Addiction	❑Yes ❑No
Breathing or Lung Problems	❑Yes ❑No		

WOMEN ONLY:
Could you be or are you planning to be pregnant? ❑ Yes ❑ No Nursing? ❑Yes ❑No
Taking oral contraceptives? ❑Yes ❑No

Have you ever taken Fosamax®, Boniva, Actonel or any other medications containing Bisphosphonates?
If yes, please explain: _____

COMMENTS: _____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN: _____ **Date**: _____

(Office Use Only) Initials: _____ Date: _____