REBECCA A. HAVEL DDS, SC

Adult Medical History

Patient Name _____ D.O.B. _____

Emergency Contact (Name/Phone Number) _____

Medical History

1. Physician_____ Address _____

2. When was your last physical examination? _____

3. Are you under the care of a physician?..... ☐ Yes ☐ No
If yes, for what reason(s)? _____

4. Are you presently taking any medications/drugs/pills/herbals/supplements?..... ☐ Yes ☐ No
If yes, please list:_____

5. (Women) Is there a chance you are pregnant? ..... ☐ Yes ☐ No
If yes, anticipated due date?_____

6. Do you take oral contraceptives? ..... ☐ Yes ☐ No

7. Are you allergic/sensitive to: ☐None ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex ☐Pine Nuts ☐Dyes
☐ Other_____

8. Do you smoke, chew or use E-cigarettes? ..... ☐ Yes ☐ No
If yes, please indicate which one(s), daily frequency and how long?_____

9. Do you have Diabetes? ..... ☐ Yes ☐ No
If Yes, please indicate ..... ☐ Type 1 ☐ Type 2 Last HbA1c date and level_____

10. Do you have, or have you ever had:

Heart trouble	☐Yes ☐No	Excessive or prolonged bleeding	☐Yes ☐No
Heart murmur	☐Yes ☐No	Thyroid problem	☐Yes ☐No
Heart surgery	☐Yes ☐No	Jaundice	☐Yes ☐No
Heart pacemaker	☐Yes ☐No	Hepatitis(Type)	☐Yes ☐No
Rheumatic fever	☐Yes ☐No	Cancer	☐Yes ☐No
Congenital heart defects	☐Yes ☐No	Chemotherapy/radiation	☐Yes ☐No
Artificial heart valve/stent/graft	☐Yes ☐No	Arthritis	☐Yes ☐No
Abnormal blood pressure	☐Yes ☐No	Artificial joint replacements	☐Yes ☐No
Stroke	☐Yes ☐No	Cortico-Steroid treatment	☐Yes ☐No
Ulcers / GERD	☐Yes ☐No	Osteoporosis/treatment w/Bisphosphonates	☐Yes ☐No
Kidney trouble/Dialysis	☐Yes ☐No	HIV positive/AIDS	☐Yes ☐No
Tuberculosis or lung disease	☐Yes ☐No	Oral herpetic lesions	☐Yes ☐No
Asthma	☐Yes ☐No	Sexually Transmitted disease	☐Yes ☐No
Sinus trouble	☐Yes ☐No	Psychiatric care	☐Yes ☐No
Epilepsy / seizures	☐Yes ☐No	Glaucoma	☐Yes ☐No
Fainting spells	☐Yes ☐No	Hearing impaired	☐Yes ☐No
Anemia	☐Yes ☐No	Chemical dependency	☐Yes ☐No
Leukemia	☐Yes ☐No	Do you take pre-medication for anything	☐Yes ☐No
		If you pre-medicate for what _____	

11. Have you had any other serious illness, hospitalization or accident? ☐Yes ☐No
If yes, please explain:_____

(OVER PLEASE)

REBECCA A. HAVEL DDS, SC

Adult Medical History

Dental History

1. Former Dentist_____ Address _____

2. When did you last visit a dentist?_____ When was your last cleaning? _____

   X-rays taken? ..... ☐ Yes ☐ No

   If yes: ☐ Full Mouth Series ☐ Bitewings ☐ Panoramic

   What was done at your last visit? _____

   Why did you leave that dentist? _____

   Has any dental treatment been recommended to you that you have not had done? _____

3. Are you aware of any dental problems? ..... ☐ Yes ☐ No

   Explain: _____

4. Please rate the present condition of your mouth. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**

5. Have you ever been treated for gum disease? ..... ☐ Yes ☐ No

   If yes, what was done?_____

6. Do you have well water? ..... ☐ Yes ☐ No

7. Is your water fluoridated? ..... ☐ Yes ☐ No

8. Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure

9. Please rate the appearance of your smile. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**

10. Would you like a whiter smile? ..... ☐ Yes ☐ No

11. Would you like straighter teeth? ..... ☐ Yes ☐ No

12. Have you had your teeth straightened/worn braces? ..... ☐ Yes ☐ No

13. Are you concerned with bad breath (malodor)? ..... ☐ Yes ☐ No

14. Are you concerned with snoring or sleep apnea? ..... ☐ Yes ☐ No

15. Are you concerned with grinding or clenching your teeth (bruxism)? ..... ☐ Yes ☐ No

16. Do you wear a bite guard? ..... ☐ Yes ☐ No

17. Are you aware of possible TMJ problems - does your jaw joint make noise, lock up or create pain? ..... ☐ Yes ☐ No

18. Are you interested in sleep/sedation dentistry?..... ☐ Yes ☐ No

19. Is there anything else that would be valuable for your dentist to know to best care for you? _____

_____

- **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.**
- **I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.**
- **I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.**

Patient Signature_____ Date _____

(Parent/Guardian)

Dentist Signature_____ Date _____