Dr. Pienkowski DDS
FAMILY DENTISTRY

Medical History

Chart #: _____

Name: _____ Date: _____/_____/20_____ Age: _____

1. Why are you here today? _____

❑ Yes ❑ No 2. Are you having pain or discomfort at this time? Where? _____
How Long? _____ What makes it worse? _____

❑ Yes ❑ No 3. Do you feel very nervous about having dental treatment? Why? _____
_____

❑ Yes ❑ No 4. Have you ever had a bad experience in the dental office? Please explain. _____
_____

❑ Yes ❑ No 5. Are you dissatisfied with the appearance of your teeth?

❑ Yes ❑ No 6. Have you been under the care of a medical doctor during the past two years?
Regular Physician's Name _____
Address _____ Phone _____

❑ Yes ❑ No 7. Are you currently taking any medications or drugs, including herbals?
If yes, please list ALL of them: _____
_____
_____

❑ Yes ❑ No 8. Have you been a patient in the hospital during the past two years?

❑ Yes ❑ No 9. Have you had surgery in the past two years? What kind? _____
Were there any complications? ❑ Yes ❑ No

❑ Yes ❑ No 10. Are you allergic to any of the following? Please check all that apply.

❑ Aspirin	❑ Nitrous Oxide	❑ Valium	❑ Penicillin
❑ Darvocet	❑ Erythromycin	❑ Latex	❑ Sulfites
❑ Codeine	❑ Local Anesthetics	❑ Tetracycline	❑ Amoxicillin
❑ Vicodin	❑ Nembutal/Seconal (sleeping pills)	❑ Other antibiotics: _____	

❑ Yes ❑ No 11. Are you aware of being allergic to ***any other*** medication, metal, or substance?
If yes, please list them: _____

❑ Yes ❑ No 12. Do you require pre-medication? ❑ I'm not sure

❑ Yes ❑ No 13. Please **check** any of the following conditions which you have had or currently have. Please review this list carefully since your health and optimal treatment outcome may depend on your responses.

❑ Artificial heart valve	❑ Congenital heart defect	❑ Heart murmur
❑ Rheumatic heart disease	❑ Bacterial endocarditis	❑ Mitral valve prolapse
❑ Artificial joints (Date of placement: _____ / _____ / _____)		
❑ Heart surgery	❑ Heart failure	❑ Angina Pectoris
❑ Heart Disease or Attack	❑ Heart pacemaker	❑ Stroke
❑ Narrow Angle Glaucoma	❑ Thyroid disease	❑ Pain in jaw joints
❑ Liver disease	❑ Hepatitis (Type ____)	❑ Abnormal bleeding
❑ Hemophilia	❑ Anemia	❑ Bruise easily
❑ High blood pressure (Controlled blood pressure: _____ / _____)		
❑ Fainting or dizzy spells	❑ Frequent headaches	❑ Epilepsy or Seizures
❑ Emphysema	❑ Persistent cough	❑ Allergies or hives
❑ Tuberculosis (TB)	❑ Hay fever	❑ Sinus trouble
❑ Asthma (Inhaler? ❑ Yes ❑ No; Last episode: _____ / _____ / _____)		
❑ Kidney trouble ❑ Diabetes (Type ❑ I ❑ II; Last Reading: _____)		
❑ Cortisone therapy	❑ Arthritis	❑ Drug addiction
❑ Chemotherapy	❑ Radiation Therapy	❑ Cancer
❑ Difficulty swallowing	❑ Severe gag reflex	❑ Ulcers
❑ HIV or AIDS	❑ Prolonged infections	❑ Psychiatric treatment
❑ Other: _____		

Notes

Continued on the next page

❑ Yes ❑ No 14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are very tired?

❑ Yes ❑ No 15. Do you snore? How do you know? _____

❑ Yes ❑ No 16. Do you smoke or use smokeless tobacco?

If yes, how many packs do you smoke per day? _____

How many years have you smoked? _____

❑ Yes ❑ No 17. Do you drink soda/pop/sweetened carbonated beverages?

If yes, how may cans or servings per day? _____

❑ Yes ❑ No 18. Do you drink sweetened beverages such as coffee, tea, fruit juices (Snapple, etc.), or sports drinks (Gatorade, etc.)

If yes, how may cups or servings per day? _____

❑ Yes ❑ No 19. Do you eat candy/donuts/sugary foods?

❑ As part of or near my meals ❑ As a snack

❑ Yes ❑ No 20. Have you ever had ❑ Braces ❑ Gum Disease ❑ Periodontal Surgery

❑ Dental Implants ❑ Jaw Surgery ❑ Removal of Wisdom Teeth

Were there any complications? _____

❑ Yes ❑ No 21. Do you wake up with soreness/stiffness/pain in your face or upper neck?

❑ Yes ❑ No 22. Do you wake up with headaches?

❑ Yes ❑ No 23. Do you have a stressful day or job?

❑ Yes ❑ No 24. Do you chew gum? ❑ < 1hour/day ❑ > 1 hour/day

❑ Yes ❑ No 25. Have you had teeth, fillings, or crowns fall out, break, or chip in your mouth?

❑ Yes ❑ No 26. Does you jaw click or hurt when you chew?

❑ Yes ❑ No 27. Do you have fluoride in your water? ❑ I'm not sure

24. When was your last dental exam? ____/____/____ X-rays? ____/____/____

25. When was your last dental cleaning? ____/____/____

26. Times a day you brush? _____ Times a week you floss? _____

27. When do you brush your teeth? ❑ Morning ❑ Evening

28. When do you floss your teeth? ❑ Morning ❑ Evening

29. Do you have bad breath? ❑ Morning ❑ Noon ❑ Evening ❑ Bedtime

❑ Yes ❑ No 30. Do you use an electric tooth brush?

❑ Yes ❑ No 31. Do you use a tongue scraper?

FOR WOMEN ONLY:

Are you pregnant? ❑ Yes ❑ No If yes, what month? _____

Are you taking birth control pills? ❑ Yes ❑ No

Notes

_____

Medical Consult Needed:

❑ Blood test

❑ Blood thinner

❑ High BP

❑ High blood sugar

❑ SBE Prophylaxis

❑ Sedation

❑ Suspicious lesion

❑ Tonsils

❑ Other: _____

To the best of my knowledge, all of the preceding answers are true and correct. I understand that this information will be held in confidence and will be used only to improve communication and treatment selection between my doctor and me. If I have any changes, I will be sure to update my medical history at the next appointment.

I hereby authorize the doctor to take any diagnostic records deemed necessary to make a thorough diagnosis of my dental needs and to perform any and all forms of treatment and therapy agreed upon by me.

_____ _____/_____/20_____

Patient's signature Date

_____ _____/_____/20_____

Signature of parent or legal guardian (please circle one) Date

Reviewed by Doctor _____ _____/_____/20_____