Loida Family Dentistry Of Ste. Genevieve

Patient Name (print)____ **Date**___________________

Dental History – Please only mark (x) the following conditions that apply to you.

Appearance
- ☐ Discolored teeth
- ☐ Worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Spaces
- ☐ Overbite
- ☐ Flat teeth

Pain/discomfort
- ☐ Sensitivity
- ☐ Pressure

Function
- ☐ Grinding/clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ)
- ☐ Difficulty Chewing
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Difficulty opening or closing

`Habits
- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/Lip biting
- ☐ Chewing on ice/
- ☐ foreign objects

Sleep Pattern
- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Bed Wetting(children)
- ☐ Sleep Apnea

- ☐ Difficulty with Extractions
- ☐ Difficulty getting numb

Social
- ☐ Tobacco , How much_________ How long_________
- ☐ Alcohol Frequency___________
- ☐ Drug Frequency_____________

Periodontal (GUM)Health
- ☐ Bleeding,swollen, irritated
- ☐ Bad Breath
- ☐ Dry Mouth

Are you on any Blood Thinners? Y or N If yes, please list ______________________________

Have you ever had to take a Antibiotic (pre-med) prior to seeing a dentist?___________________

Medical History – Please only mark (x) the following conditions that apply to you.

- ☐ **Cancer**
- ☐ Type_______
- ☐ Chemotherapy
- ☐ Radiation

Cardiovascular
- ☐ Chest Pain
- ☐ Artificial Valve
- ☐ Heart Conditions
- ☐ Heart Surgery
- ☐ High/low BP
- ☐ MVP
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Gastrointestinal
- ☐ Ulcers(stomach)
- ☐ Gastrointestinal

Hematologic/ Lymphatic
- ☐ Anemia
- ☐ Blood Disorder
- ☐ Excessive Bleeding

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Illness

Women
- ☐ Currently Pregnant
- ☐ Nursing
- ☐ Oral Contraceptives

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV
- ☐ Veneral Disease
- ☐ Shingles

Medical Allergies
- ☐ Antibiotics (penicillin/amox/clindamycin) Opioids(percocet/oxycodone)
- ☐ Latex
- ☐ Local Anesthetics
- ☐ NSAIDs
- ☐ Other Allergies

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Additional Comments

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Are you under the care of a physician? Y or N If yes, please Explain
____
____

Physician Name:___________________________ Address:____Phone:________________

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N If yes, please explain___________________________
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____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, list__________________________
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Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so please list meds
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Have you ever had a major surgery? If so what type?____
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____________________	____________________	__________	____________________
Signature of patient/legal guardian	*Print Name*	*Date*	*Providers Signature*