

Gandy Dental

Adult Medical and Dental History

Patient Name _____ D.O.B. _____

Emergency Contact (Name/Phone #) _____

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 tobacco, 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:

- | | |
|--|--|
| Abnormal blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Heartpacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart surgery <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial heart valve/stent/graft..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis (Type __) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial joint replacements <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV positive/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney trouble/Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical dependency..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy/radiation <input type="checkbox"/> Yes <input type="checkbox"/> No | Oral herpetic lesions <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis/treatmentw/Bisphosphonates <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Corticosteroid treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric care..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/seizure <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive or prolonged bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting spells <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing impaired <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid problem <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis or Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Ulcers/GERD <input type="checkbox"/> Yes <input type="checkbox"/> No |

11. Do you take pre-medication for anything? Yes No
If you pre-medicate, what for? _____

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

Adult Medical and Dental 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
- If yes, please 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)