MAXWELL THANEY, D.D.S.
HEALTHY TEETH. HAPPY SMILES.

DENTAL & MEDICAL HISTORY

Patient Name: _____ Date: _____

DENTAL HISTORY

Have you experienced any of the following (please check all that apply):		
❑ chronic bad breath	❑ grinding or clenching of teeth	❑ sensitivity to hot
❑ bleeding gums	❑ loose teeth	❑ sensitivity to sweets
❑ jaw clicking or popping	❑ periodontal treatment	❑ sensitivity when biting
❑ food collection between teeth	❑ sores or growths in mouth	❑ sensitivity to cold
❑ locking jaw	❑ broken fillings	
Other:		

Rate your smile from 1 – 10: _____ What would you change: _____

Does dental treatment make you nervous? ❑ Yes ❑ No Are you happy with past treatment? ❑ Yes ❑ No

Have you ever had a negative experience in a dental office? ❑ Yes ❑ No

Please explain: _____

Do you usually have anesthesia with your dental treatment? _____

Have you had orthodontic work in the past? _____ Dates: _____

Have you had periodontal surgery? _____ Dates: _____

How long since you've seen a dentist? _____ Were X-Rays taken? ❑ Yes ❑ No

What was done at your last dental visit? _____

Have you lost any teeth? ❑ Yes ❑ No If so, why? _____ Were they replaced? ❑ Yes ❑ No

How often do you brush? _____ Floss? _____ What type of toothbrush do you use? ❑ Soft ❑ Medium ❑ Hard

MEDICAL HISTORY

Do you have or have you had any of the following conditions (please check all that apply):			
❑ Anemia/Blood Disorder	❑ Arthritis/Rheumatism	❑ Inflammatory Disease	❑ Abnormal Bleeding
❑ Cancer/Tumor	❑ Diabetes	❑ Emphysema	❑ Respiratory/Lung Illness
❑ Epilepsy	❑ Fainting/Dizzy Spells	❑ Glaucoma	❑ Abnormal Heart
❑ Bacterial Endocarditis	❑ Artificial Heart Valve	❑ Heart Transplant	❑ Congenital Heart Disease
❑ Heart Disease/Attack/Surgery	❑ Heart Stent	❑ Hepatitis, any form	❑ Joint Replacement
❑ Kidney Disease	When placed_____	❑ Liver Disease/Jaundice	When placed_____
❑ Sore/Enlarged Lymph Nodes	❑ Psychosis	❑ Previous biopsies	❑ Radiation/Chemo
❑ Rheumatic Fever	❑ Slow Healing Mouth Sores	❑ Unintentional Weight Gain or Loss	
❑ HIV/AIDS	❑ Venereal Disease	❑ Other Conditions:_____	

Recurrent Illnesses: _____

MEDICATION INFORMATION

Are you taking any of these medications (please check all that apply):	
❑ Pre-medications for dental treatment	❑ Tagament (cimetidine) or Prilosec (omeprazole)
❑ Antacids	❑ Cardizem (diltiazem) or Calan, Isoptin (verapamil)
❑ Dilatin or Tegretol	❑ Serzone (nefazodone)
❑ Barbiturates (any)	❑ Diflucan (fluconazole) or Sporonox (itraconazole)
❑ St. John's Wort or Kava-Kava	❑ Biaxin (clarithromycin)

Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? ❑ Yes ❑ No

If so, when did treatment begin: _____ End: _____

Have you ever taken any prescription drugs such as fen-phen for weight loss? ❑ Yes ❑ No

Do you consume grapefruit juice, grapefruits or grapefruit extract? ❑ Yes ❑ No

64 North Main Street • Brockport, NY 14420
office 585.637.6884 *fax* 585.637.7087 *email* info@brockportsmiles.com www.brockportsmiles.com

MAXWELL THANEY, D.D.S.
HEALTHY TEETH. HAPPY SMILES.

DENTAL & MEDICAL HISTORY

Patient Name: _____ Date: _____

MEDICAL HISTORY CONTINUED

Physician Name: _____ Phone #: _____

Date of last health care exam: _____ Do you have any drug allergies? _____

Have you been hospitalized in the last 5 years? ❑ Yes ❑ No If yes, reason: _____

Are you currently receiving care? ❑ Yes ❑ No If yes, nature of care: _____

Please list the names and phone numbers of the physicians what are currently providing you care:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Please list all medications (prescription or non-prescription) that you are currently taking and reason for medication:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Do you have any known allergies (latex, etc.)? _____

Other known allergies? (i.e. pollen, etc.) _____

Do you drink: ❑ public water ❑ well water ❑ bottled water

Women:

Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Patient or Legal Guardian Signature: _____ Date: _____

64 North Main Street • Brockport, NY 14420
office 585.637.6884 *fax* 585.637.7087 *email* info@brockportsmiles.com www.brockportsmiles.com