Brockport Smiles
A fresh approach to dentistry
Dr. Maxwell Thaney & Associates

DENTAL AND 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	☐ Sore or growths in mouth	☐ Sensitivity to cold
☐ Locking jaw	☐ Broken fillings	

Other: ______________________________

Rate your smile from 1-10 ______________ Less than a 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 othodontic 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? ______________________________ Name of previous dentist: ______________

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 ☐ Electric

Do you clear your throat a lot or feel like something is always stuck in your throat? ☐ Yes ☐ No Do you notice a hoarseness in your voice? ☐ Yes ☐ No

Have you ever had a sleep study? ☐ Yes ☐ No If so, when? ______________________________

Have you been diagnosed with Sleep Apnea? ☐ Yes ☐ No If so, do you wear a CPAP? ☐ Yes ☐ No

MEDICAL HISTORY

Do you have or have you had any of the following conditions (please check all that apply):

☐ Anemia/Blood Disorder	☐ Abnormal Heart	☐ Diabetes	☐ Hepatitus, any form
☐ Abnormal Bleeding	☐ Congenital Heart Disease	☐ Fainting/ Dizzy Spells	☐ Glaucoma
☐ Acid Reflux	☐ Heart Disease/Attack/Surgery	☐ Phychosis	☐ Liver Disease/Jaundice
☐ Cancer/Tumor	☐ Artificial Heart Valve	☐ Depression	☐ Previous Biopsies
☐ Radiation/Chemo	☐ Kidney Disease	☐ Slow Healing Mouth Sores	☐ Unintentional Weight Gain/Loss
☐ Epilepsy	☐ Lupus	☐ Venereal Disease	☐ Joint Replacement
☐ Bacterial Endocarditis	☐ Sore/Enlarged Lymph Nodes	☐ Inflammatory Disease	When Placed __________
☐ Heart Stent	☐ Rheumatic Fever	☐ Emphysema	☐ Osteoporosis
When Placed __________	☐ HIV/ AIDS	☐ Respiratory/Lung Illness	Other conditions
☐ Heart Transplant	☐ Arthritis/ Rheumatism	☐ Sinus Problems	______________

Recurrent Illness: ______________________________

FAMILY HISTORY

Do any of your famiy have or have had any of the following conditions (please check all that apply):

☐ Diabetes	☐ Heart Disease	☐ Arthritis	☐ Gum Disease

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Patient Name: ______________________ Date: __________

MEDICAL INFORMATION

Are you taking any of these medications (please check all that apply):

- ☐ Pre-medications for dental treatment
  Reason for pre-medication ______________
- ☐ Antacids
- ☐ Dilatin or Tegretol
- ☐ Barbiturates (any)
- ☐ St. John's Wort or Kava-Kava
- ☐ Tagament (cimetidine) or Prilosec (omeprazole)
- ☐ Cardizem (diltiazem) or Calan, Isoptin (verapamil)
- ☐ Serzone (nefazodone)
- ☐ Diflucan (fluconazole) or Sporonox (itraconazole)
- ☐ 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

Physician Name: ______________________ Phone Number: __________

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 that are currently providing you care:

Name: ______________________ Phone Number: __________

Name: ______________________ Phone Number: __________

Name: ______________________ Phone Number: __________

Please list all medications (presciption 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.) __________

If prescriptions are needed what is your pharmacy of choice? __________

Do you drink: ☐ Public water ☐ Well water ☐ Bottled water

WOMEN

Are you pregnant? ☐ Yes ☐ No May be pregnant ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Patient or Legal Guardian Signature: ______________________ *Date:* __________