McLean Dentistry

Kurt C. Rolf, DDS

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○Yes or ○No
Have you ever been hospitalized or had a major operation? ○Yes or ○No
Have you ever had serious head or neck injury? ○Yes or ○No
Are you taking any medications, pills, or drugs? Please list below. ○Yes or ○No

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes or ○ No
Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonates? ○ Yes or ○ No
Have you ever been told to pre-medicate with antibiotics prior to a dental appointment? ○Yes or ○No
Do you snore? ○ Yes or ○ No
Do you have hypertension? ○ Yes or ○ No
Has anyone witnessed a sleep apnea/choking episode? ○ Yes or ○ No
Is your neck size for male >17" female >15"? ○ Yes or ○ No
Have you ever been told you have sleep apnea or do use a CPAP machine? ○Yes or ○No
Do you use tobacco? ○ Yes or ○ No

Women: Are you?
Pregnant/Trying to get Pregnant? ○ Yes or ○ No
Taking Oral Contraceptives? ○ Yes or ○ No
Nursing? ○ Yes or ○ No

Are you allergic to any of the following?
○Aspirin ○Penicillin ○Codeine ○ Local Anesthetics ○Acrylic ○Metal ○Latex ○ Sulfa Drugs
○Other, if yes, please explain:

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Do you have, or have you ever had, any of the following? Please circle your answer.

AIDS/HIV Positive	Drug Addiction	Liver Disease
Alzheimer's Disease	Emphysema	Low Blood Pressure
Anaphylaxis	Epilepsy or Seizures	Lung Disease
Anemia	Excessive Bleeding	Mitral Valve Prolapse
Angina	Excessive Thirst	Pain in Jaw Joint
Arthritis/Gout	Fainting Spells/Dizziness	Parathyroid Disease
Artificial Heart Valve	Frequent Cough	Psychiatric Care
Artificial Joint	Frequent Headaches	Radiation Treatment
Asthma	Glaucoma	Recent Weight Loss
Blood Disease	Hay fever	Rheumatic Fever
Blood transfusion	Heart Attack/Failure	Rheumatism
Breathing Problem	Heart Murmur	Scarlet Fever
Bruise Easily	Heart Pacemaker	Sickle Cell Disease
Cancer	Dementia	Stent Placement
Cataracts	Heart Trouble/Disease	Sinus Trouble
Chemotherapy	Hemophilia	Stroke
Chest Pain	Hepatitis A	Swelling of Limbs
Cold Sores/Fever Blisters	Hepatitis B or C	Thyroid Disease
Congenital Heart Disorder	Herpes	Tuberculosis
Convulsions	High Blood Pressure	Ulcers
Cortisone Medicine	Hypoglycemia	Venereal Disease
Diabetes	Kidney Problems	Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No

Please Explain _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: DATE:

_____ _____

Review by: Doctor _____ Date _____ B.P. _____

Medical Updates: _____ Date _____ Dr. _____

Medical Updates: _____ Date _____ Dr. _____

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Dental Health History

1. Are you having any discomfort at this time?
    - o Yes
    - o No

    If yes, please explain:

2. Have you ever had any serious trouble associated with previous dentistry?
    - o Yes
    - o No

    If yes, please explain:

3. Does dental treatment make you nervous?
    - o No
    - o Slightly
    - o Moderately
    - o Extremely
4. Date of your last dental visit? _____

5. Have you ever been treated for periodontal disease?
    - o Yes
    - o No

6. How often do you brush? Please circle of the texture if its: soft, medium, or hard.

7. Do you have or have you ever had any of the following? Please mark
    - o Bleeding gums
    - o Unpleasant taste/bad breathe
    - o Burning tongue/lips
    - o Frequent blister, lip/mouth
    - o Swelling lump in mouth
    - o Orthodontic Treatments (braces)
    - o Biting cheeks/lips
    - o Clicking/popping jaw
    - o Difficulty opening or closing jaw
    - o Loose teeth
    - o Sensitive to hot
    - o Sensitive to cold
    - o Sensitive to sweets
    - o Sensitive to biting
    - o Food impaction
    - o Clenching/grinding
    - o Shifting in bite
    - o Change in bite

8. Do you use the following?
    - o Electric toothbrush
    - o Dental Floss
    - o Fluoride Rinse
    - o Toothpick

9. Check one of the following: My mouth is
    - o Very comfortable
    - o Moderately comfortable
    - o Uncomfortable

10. Check one of the following: I think the appearance of my mouth is
    - o Excellent
    - o Satisfactory
    - o Dissatisfactory

11. Check one of the following: It is important for me to
    - o Keep my natural teeth
    - o Time
    - o Money

12. Check one of the following: I _____ done what my dentist recommend
    - o Always
    - o Usually
    - o Never
    - o

13. Check one of the following: Dental health is _____ priority
    - o High
    - o Low

14. These are the things that are important to me about my dental health:

    Please explain: