COMPREHENSIVE MEDICAL & DENTAL HISTORY

Patient Name _____ Date of Birth _____ Today's Date _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

EMERGENCY CONTACT NAME: _____ PHONE NUMBER: _____

How would you prefer contact from us? ☐ Text ☐ Email ☐Home Phone ☐ Cell Phone ☐ Work Phone

If you are a new patient to our practice, how did you hear about us? _____

Have you been hospitalized in the last 2 years or had any major operations or serious illnesses? ☐ YES ☐ NO

If yes, please describe: _____

Allergies _____

Latex Allergy? ☐ YES ☐ NO

WOMEN ONLY: Are you pregnant or think you may be pregnant? ☐ YES ☐ NO Breastfeeding? ☐ YES ☐NO

Do you currently (or have you ever had) any of the following conditions? (Check all that apply):

- ☐ Acid Reflux
- ☐ Artificial Heart Valve
- ☐ Artificial Joint (Date_____)
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism/Asperger
- ☐ Bleeding Disorder (Anemia, Hemophilia)
- ☐ Cancer/Tumor
- ☐ Chemical Dependency
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Fainting/Dizzy
- ☐ Frequent Cold Sores
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Attack (Date _____)
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Lung Disease (COPD)
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Radiation/Chemo
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach/Intestinal
- ☐ Stroke (Date_____)
- ☐ Thyroid condition
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Other _____

Do you currently (or have you ever used) tobacco products? ☐ NO ☐ YES, currently ☐ YES, but no longer

How frequently? _____ ☐ CIGARETTE ☐ CIGAR ☐ SNUFF ☐ DIP ☐ OTHER

Have you ever taken medications (such as bisphosphonates) that affect bone or to prevent bone disease (ie. Fosamax, Zometa, Actonel, Aredia)? ☐ YES ☐ NO

If applicable, are you required to take a premedication prior to your dental appointment (ie. joint replacement, history of infective endocarditis)? ☐ YES ☐ NO

If yes, reason: _____

Are you currently taking any Medications? ☐ YES ☐ NO **If Yes Please List All Medications Below:**

Drug Name	Dosage	Reason

☐ **Please see the attached list of additional current medications**

Southpark art dentistry
2700 COLTSGATE ROAD, SUITE 100
CHARLOTTE, NC 28211
(704) 362-4646

Previous Dentist Name _____ City/State _____

Date of Last Dental Visit _____ Date of Last Dental X-rays _____

1.) Mark if you have had any of the following conditions? (Check all that apply):

- ☐ Anxiety with dental treatment
- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on Lips/Mouth
- ☐ Burning tongue
- ☐ Chew on one side of your mouth
- ☐ Clicking or popping jaw
- ☐ Dry Mouth
- ☐ Fingernail biting
- ☐ Food collection between the teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Ortho treatment (Date _____)
- ☐ Pain with teeth
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity to chewing
- ☐ Sores in your mouth

2.) How often do you floss your teeth? _____

3.) What is your main concern with dental treatment (ie. Time, Expense, Fear, etc)? _____

4.) What is your main concern or dental problem? _____

5.) How do you feel about your smile? Do you wish your teeth were whiter, straighter, etc? _____

To the best of my knowledge, the preceding answers are correct. If I have any changes in my health status, or if my medication changes, I will inform the dentist and staff at the next appointment.

Signature: _____ Date: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other

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