David A. Tecosky, DMD

Patient Name ____________________________ Date of Birth ______________________ Date _________________

Dental History

Previous Dentist ____ Last Visit _________________

Reason for not returning to previous dentist ____

Have you ever had complications associated with dental treatment? Y/N If yes, please explain __________________

____

How many times do you: brush/day? ______ floss/week? _______ Do your gums bleed? Y/N

Have you ever been told you have periodontal disease? Y/N Were you treated Y/N When? __________________

Are your teeth sensitive to: hot Y/N cold Y/N sweets Y/N other: ________________________

Do you clench/grind your teeth: while sleeping? Y/N during the day? Y/N

Do your jaws: feel tired? Y/N click? Y/N lock? Y/N Have you been diagnosed with TMJ Disorder? Y/N

Do you have frequent or severe headaches? Y/N Are you missing any teeth? Y/N

Have you ever been told by a dentist you need to wear a night guard? Y/N If yes, do you wear one? Y/N

Have you ever had any injuries to your face/jaw? Y/N Specify ____

Did you ever have orthodontic treatment? Y/N Have you had your wisdom teeth extracted? Y/N

Do you wear full or partial removable dentures? Y/N If yes, how long have you had them? ______ Top/Bottom/Both

Are you satisfied with the appearance of your teeth/smile? Y/N If no, why not? ______________________________

Are you interested in whitening your teeth? Y/N

Please add anything you feel is important for us to know. ____

____

Medical History

Primary Physician ______________________________ Specialist _________________________________

Have you ever been treated for any of the following? (Please circle Y or N and clarify all Y answers by circling the condition.)

Y/N Abnormal Bleeding/Hemophilia/Bleeding Disorders

Y/N Alcohol/Drug Abuse

Y/N Anemia

Y/N Arthritis/Osteoporosis

Y/N Artificial Joints/Heart Valves

Y/N Asthma/Emphysema/Difficulty Breathing

Y/N Lung Disease/TB

Y/N Allergies/Hay Fever/Sinus Disease

Y/N Epilepsy/Seizures/Fainting Spells

Y/N Glaucoma

Y/N Heart Murmur/Mitral Valve Prolapse

Y/N Heart Attack or Surgery/Pacemaker/Stroke

Y/N Diabetes: Type 1/Type 2 Hypo/Hyper Glycemia

Y/N Tobacco Use: Current/Former
Cigars/Cigarettes/Smokeless Tobacco

Y/N STD/HIV/AIDS

Y/N Liver Disease/Kidney Problems

Y/N Thyroid Disease/Jaundice/Hepatitis A/B/C

Y/N Rheumatic Fever/Scarlet Fever

Y/N High/Low Blood Pressure

Y/N Neurological Disorders

Y/N Psychiatric Problems

Y/N Sickle Cell Disease/Trait

Y/N Shingles/Lupus/Scleroderma

Y/N Cancer (specify) ________________________
____

Y/N Allergies to Latex/Medications/Other: Specify
____

Y/N Sleep Disorders: ________________________

Y/N Do you have any conditions not listed, we should know about? ____
____

Women Only: Are you on birth control? Y/N Are you nursing? Y/N Are you pregnant? Y/N Due Date _________

Family History:

Y/N Heart Disease/Diabetes/Periodontal Disease If yes who? ____

The information I have given today is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____ _____________________________

Signature Date

(OVER→)

Patient Name___________________________________ Date of Birth _________________ Date _________________

Pharmacy _______________________ _____________________________________ ________________________

Name Address Phone

Please list all prescription and over the counter medications, herbal supplements and vitamins you are taking.

Name	Dose	When started/Why

The information I have provided is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medication, whether it be prescription or over the counter.

____ ____________________________________

Signature Date

***************************************OFFICE USE ONLY***

Medical History Update

Date/Initial	Changes