

Lifetime Dental Care Medical Screening

Name: _____ D.O.B. _____ SEX _____ SS # _____

Home Address: _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

E-Mail Address _____ Physicians Name _____

Are you under physicians care? Y _____ N _____ Condition _____

MEDICATIONS INCLUDING OVER THE COUNTER OR HERBAL MEDICATIONS:

Cardiovascular

- Congenital heart disease including MVP or heart murmur?
- Rheumatic fever, scarlet fever?
- Heart attack, heart surgery, implant, or pacemaker?
- Heart palpitations, irregular heart beat, chest pain or angina?
- High or low blood pressure?
- Have you ever **Pre-medicated** for dental treatment?
- Have you ever taken Fen-Phen or Redux?

Pulmonary disease

- Lung disease
- Asthma, pneumonia, tuberculosis, (self or family member)

CNS

- Epilepsy or seizure disorders
- Stroke
- Anxiety, depression, schizophrenia
- Hematologic
- Blood disorders/Abnormal bleeding Problems

HEENT

- Glaucoma or other eye problems
- Ear, nose, throat problems including sinus trouble

G.I.

- G.I. disorders, liver disease
- Hepatitis/Jaundice (self or family)

Sleep Apnea

- Do you have Sleep Apnea?
- Do you use a CPAP/BiPAP?
- Date of last sleep study _____

Allergies

- Allergic reaction to **Penicillin**, antibiotics, anesthetics or other medications
- Sensitive to metals or **Latex** products

G.U.

- History of kidney disease/dialysis
- Have you ever tested positive for HIV?
- Sexually transmitted disease syphilis, Gonorrhea, herpes?

Endocrine

- Diabetes, Thyroid problems
- Women only
- Is there any possibility you may be pregnant?
- Are you nursing?

Musculoskeletal

- Arthritis, painful joints, rheumatism
- Artificial joints, Implanted devices of any kind.

Other Illnesses

- Cancer or Tumor
- Radiation or chemotherapy
- Do you have any medical problem, disease or condition not listed?

Social

- Tobacco use (cigarettes, cigars, pipe, chewing tobacco, snuff?) amount _____
- How many alcoholic drinks do you have each day?

- Would you like to speak privately to the doctor about any problem?

Dental

Reason for today's visit _____

Previous Dentist's name _____

Reason for leaving your previous dentist _____

Date of last dental exam _____ Date of last dental x-rays _____

How often do you brush your teeth? _____ How often do you floss? _____

Please check any of the following conditions that apply to you:

____ Bad breath

____ Loose teeth or broken fillings

____ Bleeding gums

____ Sensitivity to cold

____ Clicking or popping jaw

____ Sensitivity to hot

____ Food collection between teeth

____ Sensitivity to biting

____ Grinding teeth

____ Sores in and around mouth

If you could change one thing about your smile, what would it be? _____

Would you be interested in further information about the newest bleaching technique? Y / N

Do you snore? Y / N Do you have excessive daytime sleepiness? Y / N

How does the patient wish to be addressed? _____

Who may we thank for referring you to our office? _____

AUTHORIZATION

I certify that I have read and understood this information to the best of my knowledge. All the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to specialist health practitioners.

X _____
Signature of patient (or parent if minor) **Date**

X _____
Signature of dentist **Date**