Dental Partners of Newburyport

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www.dentalpartnersofnewburyport.com

MEDICAL & DENTAL HISTORY QUESTIONNAIRE

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively in a way that watches out for your overall health and well-being.

Physician's Name, Address & Phone Number: _____

_____

What was the date (or approximate date) of your last medical exam? _____

How would you assess your general health? ☐ Good ☐ Fair ☐ Poor

Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition?
☐ Yes ☐ No

Have you been hospitalized within the last year? ☐ Yes ☐ No
If yes, please explain: _____

_____

Have you had a serious illness or operation within the last year? ☐ Yes ☐ No
If yes, please explain: _____

_____

Have you ever had any serious medical trouble associated with any dental experience?
☐ Yes ☐ No
If yes, please explain: _____

_____

Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment?
☐ Yes ☐ No
If yes, please explain: _____

_____

Have you ever had any type of heart surgery?
☐ Yes ☐ No

If yes, please explain: _____

_____

DO YOU NOW, OR DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES AND/OR HEALTH ISSUES?

DIABETES? ☐ **Yes** ☐ **No**
If yes, do you require insulin? Type? Dose: _____

ARTIFICIAL JOINT? ☐ **Yes** ☐ **No**
If yes, which joint? When?: _____

HEPATITIS? ☐ **Yes** ☐ **No** If yes, which type?: _____

PLEASE CHECK ALL THAT APPLY:

- ☐ Allergies-Seasonal/Environmental
- ☐ Angina
- ☐ Arthritis/Joint Disease
- ☐ Bleeding or Clotting Issue
- ☐ Cancer
- ☐ Chronic/Recurring Sinus Problems
- ☐ Eating Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Mental Health Treatment
- ☐ Pacemaker
- ☐ Serious/Frequent Headaches
- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood Disorder
- ☐ Chemotherapy/Radiation
- ☐ Drug or Alcohol Treatment
- ☐ Epilepsy or Other Seizures
- ☐ Heart Defects-Congenital
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Rheumatic Heart Disease or Rheumatic Fever
- ☐ Stroke

Please list any other medical condition(s) you have ever had: _____

_____

Do you consider yourself currently under an ABNORMALLY high amount of stress?

☐ Yes ☐ No

Do you currently use any of the following? ☐ Cigarettes ☐ Pipe ☐ Cigar

☐ Marijuana ☐ Vapor/Electronic Cigarettes ☐ Smokeless Tobacco

Please describe your typical usage: _____

_____

How much alcohol do you consume each week? _____

Please indicate if you are currently taking, or within the past year have taken, any of the following medications:

- ☐ Antibiotics
- ☐ Antihistamines
- ☐ Blood Thinners
- ☐ Cholesterol Medication
- ☐ Hormones (Birth Control, Estrogen, etc.)
- ☐ Heart Related Medication
- ☐ Sleep Aide Medication
- ☐ Vitamins
- ☐ Antidepressants/Mood Disorder Medications
- ☐ Blood Pressure Medication
- ☐ Cortisone (Prednisone, etc.)
- ☐ Decongestants
- ☐ Insulin
- ☐ Osteoporosis Medications (Bone Density Medication
- ☐ Thyroid Medication
- ☐ Pain Medication-Prescription
- ☐ OTC (Over the Counter) Pain Medication (Aspirin, Advil, Tylenol, etc.)

Please list all current medications you are taking, including vitamins and over the counter medications:

_____

_____

_____

Are you ALLERGIC to or have you ever had a reaction to:

- ☐ Antibiotics (Penicillin, Tetracycline, etc.)
- ☐ Codeine
- ☐ Local Dental Anesthetics (Novacaine)
- ☐ Aspirin

Please list any other medications you are allergic to or have had an adverse reaction to:

_____

Please list any other disease, condition or problem you are experiencing, no previously listed, that you feel we should know about: _____

_____

WOMEN ONLY:

Are you currently pregnant? ☐ Yes ☐ No Expected Delivery Date: _____

Are you currently nursing? ☐ Yes ☐ No

DENTAL QUESTIONS:

Please describe why you are here today: _____

_____

When was your last visit to the dentist? What was done? _____

_____

How often do you visit the dentist? _____

Which best describes you?

☐ I prefer to wait until something hurts or is broken before I have it fixed.

☐ I prefer preventive care to try and avoid problems.

Have you had any complications in a dental office? If yes, please describe: _____

_____

Do you have any teeth that are sensitive to any of the following? (Please check all that apply):

☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

Please describe: _____

Please check all that apply:

☐ Have you ever been aware that you grind your teeth?

☐ Have you ever been aware that you clench your teeth?

☐ Have you ever worn or been told about a night guard?

☐ Has anyone ever heard you hold your breath during sleep?

☐ Are you aware of any family history of sleep apnea?

☐ Do you typically feel fatigued/would like to nap during the day?

☐ Have you ever been on a CPAP?

☐ Have you ever had a sleep study?

☐ Have you ever been told you snore?

Have you ever had braces? If so, approximately when? _____

Does your jaw ever click or pop? Where? When? _____

_____

Do you get frequent headaches? Please describe: _____

_____

Please check if you use any of the following:

☐ Manual Toothbrush ☐ Electric Toothbrush ☐ Floss ☐ Waterpik

☐ Interdental Brushes

Please describe any other dental aids you may use: _____

_____

I certify that I have read and understand the questions above. Any questions that I had in regards to these questions have been answered to my complete satisfaction. I will not hold Dr. St. Clair or any other member of the staff of this office, responsible for any errors or omissions that I may have made in completion of this form. I will advise this office and Dr. St. Clair of any changes in my physical, dental or general health condition, as well as changes in my medications.

AUTHORIZATION

Signature of Patient, Parent or Guardian:

_____

Relationship to Patient: _____

Response Date: _____