ANACONDA DENTAL WORKS
Katherine S. Slocum, DDS

PATIENT MEDICAL HISTORY (Confidential)

Patient's Name ______________________ Date: __________

Your Physician's Name ______________________ Phone: __________

Date of Last Exam (okay to estimate) ______________________

1. Are you currently under medical treatment? □Yes □No
2. Have you ever been hospitalized for any surgical operation or serious illness? □Yes □No
   If yes, please explain______________________
3. Are you taking any prescription or non-prescription medications, vitamins, herbs, or minerals? □Yes □No
   If yes, please list: ______________________
4. Do you use tobacco? If yes, list type and amount per day.______________________ □Yes □No
5. Do you have a history of illegal drug, prescription medication or alcohol abuse? □Yes □No
6. Are you allergic to **or** have you had any reactions to the following?

a. Local Anesthetics (eg. Novocaine)	□Yes □No	f. Latex Rubber	□Yes □No
b. Metals (Nickle, mercury, etc.)	□Yes □No	g. Pain medication	□Yes □No
c. Antibiotics (Penicillin, etc)	□Yes □No	h. Sulfa Drugs	□Yes □No
e. Barbiturates, sedatives, sleeping pills	□Yes □No	i. Other (please list)	□Yes □No
d. Foods	□Yes □No	**Type of reaction**__________	

7. Women:

a. Are you pregnant or think you may be pregnant?	□Yes □No
If yes, number of weeks?	
b. Are you trying to get pregnant?	□Yes □No
c. Are you nursing?	□Yes □No
d. Are you taking oral contraceptives?	□Yes □No
e. Have you reached menopause? Symptoms?	□Yes □No

8. Do you have **or** have you had any of the following?

Epilepsy / Seizures	□Yes □No	Anemia/blood transfusion	□Yes □No	Glaucoma	□Yes □No
Neurologic disorder	□Yes □No	Allergies/hay fever	□Yes □No	Kidney Disease	□Yes □No
Sleep Disorder	□Yes □No	Asthma-hospitilized for?	□Yes □No	Liver Disease	□Yes □No
Stroke/TIA	□Yes □No	Bronchitis	□Yes □No	Thyroid Disease	□Yes □No
Angina / Chest Pains	□Yes □No	COPD	□Yes □No	Arthritis	□Yes □No
Cardiac Pacemaker	□Yes □No	CPAP/oxygen use	□Yes □No	Autoimmune disease	□Yes □No
Cardiovascular disease	□Yes □No	Emphysema	□Yes □No	Joint Replacement	□Yes □No
Congestive heart failure	□Yes □No	Sinus trouble	□Yes □No	Osteoporosis	□Yes □No
Damaged heart valves	□Yes □No	Tuberculosis	□Yes □No	AIDS or HIV infection	□Yes □No
Heart Attack	□Yes □No	Cancer	□Yes □No	Sexually transmitted disease	□Yes □No
High Blood Pressure	□Yes □No	Chemo/radiation therapy	□Yes □No	Other	
Low Blood Pressure	□Yes □No	Diabetes-Type I or II	□Yes □No	Other	
Abnormal bleeding	□Yes □No	GERD/ulcers	□Yes □No	Other	

Doctor's Comments: ______________________

9. **Have you ever been treated with oral or intravenous bisphosphonates?** **□Yes □No**
   For bone pain, hyercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

PATIENT DENTAL HISTORY (Confidential)

Name of Previous Dentist and Location: Date of Last Exam:

1. Do you currently feel pain in any of your teeth? □Yes □No
2. Do your gums bleed while brushing or flossing? □Yes □No
3. Are your teeth sensitive to any of the following?
   a. Hot or cold liquids/foods □Yes □No
   b. Sweet or sour liquids/foods □Yes □No
4. Do you have any sores or lumps in or near your mouth? □Yes □No
5. Have you had any head, neck or jaw injuries? □Yes □No
6. Have you ever experienced any of the following jaw problems?
   a. Painful popping or clicking □Yes □No
   b. Difficulty in opening or closing □Yes □No
   c. Difficulty in chewing □Yes □No
   d. Pain to the side of face, ear, or jaw joint □Yes □No
7. Do you have frequent headaches? □Yes □No
8. Are you aware that you clench or grind your teeth? □Yes □No
9. Do you bite your lips or cheeks frequently? □Yes □No
10. Do you wear dentures or partial dentures? □Yes □No
11. Have you had orthodontic treatment? □Yes □No
12. Do you like your smile? □Yes □No
13. Have you received oral hygiene instructions regarding your gums and teeth? □Yes □No
14. Do you have anxiety regarding dental treatment? □Yes □No
15. Have you ever had any complications following dental treatment? □Yes □No

Doctor's Comments:

16. Do you brush your teeth, and at what frequency? Daily Weekly Never (circle one)
17. What type of toothbrush do you normally use? Manual Electric (circle one)
18. What type of toothpaste do you use?
19. Do you clean between your teeth, if so how? Floss Toothpicks Proxibrushes Other (circle one)
20. Do you use mouthwash, if so what type? □Yes □No

Additional Comments:

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above 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 me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature of patient (or parent if minor)

Date