SWANSON Dental Associates

MEDICAL HISTORY

Physician's Name: ________________________ Date of Last Visit: __________

Have you ever been told by a physician or dentist that you should pre-medicated with an antibiotic prior to dental visits? yes/no

Have you had any cosmetic/implant procedures? If yes, please provide us with physician name and contact information below. yes/no

Doctor's name________________________ Phone________________________

1. Are you currently being treated for a medical condition? yes/no
2. Have you ever had any serious illnesses or operations? yes/no
3. Are you currently taking any medications? yes/no
   Are you currently taking the medication Fosomax? yes/no
   Have you taken Fosomax in the past? yes/no
   Please list all medications: ____________
   ____
4. Do you take aspirin? yes/no
5. Do you smoke? yes/no
   Quantity/Frequency? __________
6. Do you use chewing tobacco? yes/no
   Quantity/Frequency? __________
7. Do you use alcohol? yes/no
   Quantity/Frequency? __________
8. Do you use cocaine or other drugs? yes/no
   Quantity/Frequency? __________
9. Do you wear contact lenses? Yes/no
10. Have you had any allergic reactions to the following:
    - Local Anesthetics (i.e. novacaine) yes/no
    - Penicillin or other Antibiotics yes/no
    - Sulfa Drugs yes/no
    - Barbiturates (codeine) yes/no
    - Sedatives (valium) yes/no
    - Iodine yes/no
    - Aspirin yes/no
    - Nickel or other metals yes/no
    - Other: ______________ yes/no
11. (Women Only) Are you:
    - Pregnant? yes/no
    - Nursing? yes/no
    - Taking birth control pills? yes/no
    - Hormone Replacement Therapy? yes/no
12. Have you ever taken Phen Phen? yes/no
13. Do you take herbal supplements? yes/no

Please check all that apply:

Aids/HIV	yes/no	Fainting	yes/no	Nervous Disorders	yes/no
Allergies	yes/no	Glaucoma	yes/no	Pacemaker	yes/no
__________		Hay Fever	yes/no	Radiation Treatment	yes/no
__________		Head Injuries	yes/no	Respiratory Problems	yes/no
Arthritis	yes/no	Heart Disease	yes/no	Rheumatic Fever	yes/no
Artificial Joints	yes/no	Heart Murmur	yes/no	Sinus Problems	yes/no
Asthma	yes/no	Hepatitis	yes/no	Stomach Problems	yes/no
Blood Disease	yes/no	High Blood Pressure	yes/no	Stroke	yes/no
Cancer	yes/no	Jaundice	yes/no	Tuberculosis	yes/no
Diabetes	yes/no	Kidney Disease	yes/no	Tumors	yes/no
Dizziness	yes/no	Liver Disease	yes/no	Ulcers	yes/no
Epilepsy	yes/no	Mental Disorders	yes/no	Venereal Disease	yes/no
Excessive Bleeding	yes/no	Mitral Valve Prolapse	yes/no	Other: __________	yes/no

DENTAL HISTORY

Former Dentist: ____________________ Date of Last X-rays? __________

City, State: __________ Phone:__________ How often Do You Floss? __________

Date of Last Dental Visit: __________ How Often Do You Brush? __________

Do you need antibiotic pre-medication for dental treatment? Yes/no What was usually prescribed? __________

Please check all that apply:

Finger nail biting	yes/no	Clench/Grind Teeth	yes/no	Sensitivity when biting	yes/no
Lip or Cheek biting	yes/no	Orthodontic Treatment	yes/no	Tooth pain	yes/no
Dental fears	yes/no	Frequent headaches	yes/no	Bad Breath	yes/no
Unfavorable dental experiences	yes/no	Jaw clicking or pain	yes/no	Bleeding Gums	yes/no
Blisters on lip or mouth	yes/no	Sensitivity to cold	yes/no	Loose teeth	yes/no
Pain around ear	yes/no	Sensitivity to heat	yes/no	Periodontal treatment	yes/no
Jaw, Head or Neck injuries	yes/no	Sensitivity to sweets	yes/no	Broken fillings	yes/no
Dry mouth, throat and/or eyes	yes/no				

Unhappy with appearance of your teeth? yes/no

Unhappy with the color of your teeth? yes/no

Unhappy with the size/shape/position of your teeth? yes/no

Problems with effectiveness or bad reaction to dental anesthetic? Yes/no

Do new people/places make you anxious? yes/no

Do you sweat or tremble during dental exams? yes/no

Awaken with an awareness of your teeth or jaws? yes/no