LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

# DENTAL & HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

## I. DENTAL HISTORY

Why have you come to see us today? ☐ Relief of pain ☐ Preventive care ☐ Improve my smile ☐ Replace missing teeth ☐ Improve chewing ☐ Second opinion ☐ Other _____

Former Dentist/Dental Office: _____ Date of most recent dental exam: _____

Reasons for changing dentists? _____ Date of most recent dental treatment: _____

**Please select Yes or No for every question. If you do not understand a question, please ask a member of our team for assistance.**

1. Yes No I currently have pain with my teeth, gums, or mouth.
2. Yes No I have problems eating.
3. Yes No I avoid brushing part of my mouth due to pain.
4. Yes No I have loose or broken teeth or fillings.
5. Yes No I have sores or growths in my mouth.
6. Yes No My gums bleed while brushing or flossing.
7. Yes No I have had periodontal treatment or a deep cleaning.
8. Yes No I have had facial or jaw injury or surgery.
9. Yes No I have had braces or orthodontic treatment in the past.
10. Yes No I have trouble getting/staying numb with dental treatment.
11. Yes No My jaw clicks, pops, locks, becomes tired, or is painful.
12. Yes No My teeth are sensitive to hot, cold, and/or sweets.
13. Yes No I have sensitivity, discomfort, or pain when biting or chewing.
14. Yes No I clench or grind my teeth during the day or while sleeping.
15. Yes No I have dry mouth.
16. Yes No I have had oral cancer, precancerous lesions, or abnormal biopsies.
17. Yes No I have family history of oral cancer, precancerous lesions, or abnormal biopsies.
18. Yes No I want to change or improve my smile.
19. Yes No I want to straighten my teeth.
20. Yes No I want to whiten my teeth.

21. Have you ever had other problems with or complications after dental treatment, including dental implants? Yes No If so, please explain: _____

22. How often do you floss? ☐ Never ☐ Less than once a week ☐ 1-3 times per week ☐ 4-6 times per week ☐ Daily or more

23. How often do you brush? ☐ Less than once daily ☐ Once daily ☐ Twice daily ☐ More than twice daily

24. Is there anything else you would like us to know about your dental care or today's visit? _____

## II. HEALTH HISTORY

Primary Care Physician's Name: _____ Date of most recent visit: _____

Preferred Pharmacy Name:_____ Address:_____ Phone: _____

**INDICATE IF YOU HAVE OR HAVE HAD THE FOLLOWING CONDITIONS, OR IF YOU ARE TAKING OR HAVE TAKEN THESE DRUGS:**

25. Yes No High blood pressure
26. Yes No Heart attack
27. Yes No Heart murmur
28. Yes No Irregular heartbeat or AFib
29. Yes No Congenital heart defect
30. Yes No Prosthetic heart valve
31. Yes No Pacemaker or implanted cardiac device
32. Yes No Congestive heart failure
33. Yes No Other heart disease or problems
34. Yes No Anemia
35. Yes No Hemophilia, other bleeding issues
36. Yes No Blood transfusions
37. Yes No Blood thinner medication(s)
(Eliquis, Xarelto, Plavix, Warfarin/Coumadin)
Name of Medication _____
38. Yes No High Cholesterol
39. Yes No Stroke, TIA
40. Yes No Diabetes ☐ Type I ☐ Type 2
Most Recent HbA1c_____ Date_____
41. Yes No GLP-1 Medications
42. Yes No Asthma
43. Yes No Sleep Apnea
☐ CPAP ☐ Oral Appliance ☐ Implanted Device
44. Yes No COPD, Emphysema, Chronic Bronchitis
45. Yes No Tuberculosis
46. Yes No Other respiratory problems
47. Yes No Cancer
Type _____ Date_____
48. Yes No Chemotherapy
49. Yes No Radiation
50. Yes No Kidney Disease
51. Yes No Liver Disease
52. Yes No Hepatitis Type _____
53. Yes No Thyroid or adrenal problems
54. Yes No Organ transplant
55. Yes No Osteoporosis or related medication(s)
(Fosamax, Boniva, Actonel, Reclast, Prolia, Xgeva, Zometa)
If Yes, which medication(s):_____
☐ Currently Taking ☐ Previously Took
Administration Route: ☐ Oral ☐ Injection ☐ IV
56. Yes No Artificial joint
57. Yes No Dementia / Alzheimer's
58. Yes No Anxiety, depression, other psychiatric care
59. Yes No Sinus problems
60. Yes No Stomach problems, ulcers
61. Yes No Epilepsy or seizures
62. Yes No Fainting or dizziness
63. Yes No Glaucoma or other eye diseases
64. Yes No Autoimmune disorders (Sjögren's, Hashimoto's, etc)
65. Yes No Skin diseases
66. Yes No Herpes / Cold Sores
67. Yes No HIV/AIDS
68. Yes No Sexually transmitted infections (HPV, syphilis, etc.)
69. Yes No Tobacco / Nicotine in any form
If yes, ☐ Former ☐ Current
TYPE(S): ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless ☐ Vape
70. Yes No Alcohol ☐ Occasional ☐ Weekly ☐ Daily
71. Yes No Marijuana, cannabis, or recreational drugs
If yes, ☐ Former ☐ Current
TYPE(S): _____

72. Yes No Current prescription and/or over-the-counter medications, vitamins and supplements, natural remedies? If yes, please list: _____

73. Yes No Medication Allergies: ☐ Penicillin ☐ Azithromycin ☐ Clindamycin ☐ Other medications: _____
74. Yes No Other allergies: ☐ Latex ☐ Adhesives ☐ Metals ☐ Foods ☐ Other:_____ Reaction: _____
75. Yes No Direction from physician to avoid: ☐ Ibuprofen or other NSAIDs ☐ Acetaminophen/Tylenol ☐ Other pain medications ☐ Antibiotics ☐ Other:_____
76. Yes No Surgeries Please list each surgery and year they were performed _____
77. Yes No Other medical conditions, problems, or medical history NOT already listed on this form? If so, please describe: _____

**WOMEN'S REPRODUCTIVE HEALTH:**

78. Yes No Taking birth control
79. Yes No ☐ Pregnant ☐ Possibly Pregnant ☐ Trying to Become Pregnant ☐ Nursing Estimated due date, if applicable: _____

***I certify that the information provided is complete and accurate to the best of my knowledge. I understand that my medical and dental history, medications and allergies may affect the dental care I receive. I agree to notify Lakeside Dental of any changes in my health, medications, allergies or pregnancy status. I understand that the dentist or dental team may ask additional questions or request consultation with another healthcare provider when appropriate.***

Patient's / Guardian's signature: _____ Doctor's signature: _____ Date: _____