Patient Medical Information

South Pointe Dental

Title	**First Name**	**Surname**	
		Email	
Date of birth	**Occupation**	**Employer**	
Address		**Referred By**	
		Postal Code	
Tel Contact	**Home:**	**Work:**	
	Mobile:		
Emergency Contact		**Emergency Contact Number**	

Are you being treated for any medical condition at the present or or have you been treated within the last year?
Yes ☐ No ☐ Not Sure ☐

If so, why? _____

When was your last medical check-up? _____

Has there been any change in your general health in the last year?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Are you taking any medications, non-prescription drugs or herbal suplements of any kind?
Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

Do you have any allergies? If you answered yes, please list using the categories below:
Yes ☐ No ☐ Not Sure ☐

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had a peculiar or adverse reaction to any medicines or injections?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have or have you ever had asthma?
Yes ☐ No ☐ Not Sure ☐

Type of puffer _____

Do you have or have you ever had any heart or blood pressure problems?
Yes ☐ No ☐ Not Sure ☐

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
Yes ☐ No ☐ Not Sure ☐

Have you ever had hepatitis, jaundice or liver disease?
Yes ☐ No ☐ Not Sure ☐

Which type of hepatitis? _____

Do you have a prosthetic or artificial joint?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have bleeding problem or bleeding disorder?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

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Have you ever been hospitalized for any illness or operations?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

Yes ☐ No ☐ Not Sure ☐

Do you have or have you ever had any of the following? Please Check

☐ Alzheimers	☐ Digestive Disorders / Acid Reflux	☐ Hypo/Hyperglycemia	☐ Rheumatic Fever
☐ Angina	☐ Drug / Alcohol Dependency	☐ Kidney Disease	☐ Sexually Transmitted Infection
☐ Anemia	☐ Emphysema	☐ Lung Disease	☐ Shortness of Breath
☐ Arthritis	☐ Epilepsy or Seizures	☐ Lupus	☐ Steroid Therapy
☐ Blood Transfusion	☐ Fibromyalgia	☐ Migraine	☐ Stomach Ulcers
☐ Cancer	☐ Head/Neck Injury	☐ Mitral Valve Prolapse	☐ Stroke
☐ Chest Pain	☐ Heart Attack	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ Thrush
☐ Cold Sores	☐ Heart Murmur	☐ Pacemaker	☐ Thyroid Disorder
☐ Diabetes Type 1	☐ High/Low Blood Pressure	☐ Parkinsons Disease	☐ TMJ Disorder
☐ Diabetes Type 2	☐ Hodgkins Disease	☐ Radiation/Chemotherapy	☐ Tuberculosis

Are there any conditions or disease not listed above that you have or have had?

Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes ☐ No ☐ Not Sure ☐

Are you nervous during dental treatment?

Yes ☐ No ☐ Not Sure ☐

WOMEN: Are/Could you be pregnant?

_____

_____

WOMEN: Are you currently breastfeeding?

_____

_____

Do you have dental insurance?

Policy/Group# **Certificate/ID#**

_____

_____

Patient Dental History

South Pointe Dental

When was your last dental visit? _____

When did you last have dental x-rays taken? _____

How often do you brush your teeth? _____

How often do you floss? _____

	Yes	Don't Know or N/A:	No
Have you been seeing a dentist regularly?	☐	☐	☐
Do any of your teeth ache?	☐	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐	☐
Do your gums bleed when you brush?	☐	☐	☐
Do you have any pain when you chew?	☐	☐	☐
Do you feel that you have bad breath?	☐	☐	☐
Have you ever been in a vehicle accident or experienced any blows to your jaw?	☐	☐	☐
Have you ever had any implant surgery in your jaw or either jaw joints?	☐	☐	☐

If you answered yes to the last question, who performed the surgery and when was it done?

_____ Date _____

Are you being followed-up by a dentist specialist? _____

Do you have any problems with your jaw joint (pain, sounds, limited opening, locking, popping)?

Is there anything about the appearance of your teeth tha you would like to change? _____

Please list anything not mentioned above regarding your past dental history:

_____

_____