Kosnic & Murphy Dental

kosnicdental

1200 S. Livernois • Rochester Hills, MI 48307-2978

ejkosnicdds1@comcast.net

(248)656-2700

Medical History

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ___-____ (Zip Code)

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Food Dye
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy - Vicodin
- ☐ Allergy -Amoxicillin
- ☐ Allergy-Acetaminophe
- ☐ Allergy-Clindamycin
- ☐ Allergy-Erythromycin
- ☐ Allergy-Hydrocodone
- ☐ Allergy-Tetracycline
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Carbocaine - Use
- ☐ Celiac Disease
- ☐ Chemo/Radiation
- ☐ Coumadin
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Emotional Disorders
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Gluten
- ☐ Head Injuries
- ☐ Heart Issues
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mumps-Measles-Ckpox
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Prob/Ulcers
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Tumors

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Subject to frequent headaches
- ☐ Tobacco/Alcohol Use
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant
- ☐ Do you snore
- ☐ Do you have Sleep Apnea

List all medications (prescription and non-prescription) including regular doses of aspirin:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain. ◯ Yes ◯ No

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

Please rate your overall health.

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly? ◯ Yes ◯ No

How many alcoholic drinks do you consume per week? _____

Name of your physician: _____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

Dental History

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you experienced popping and/or clicking of your jaw joint
☐ Have you ever experienced jaw pain
☐ You have difficulty chewing
☐ You clench or grind your teeth
☐ You wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Experienced gum recession

Please check any of the following that you have experienced.

☐ Cleanings ☐ Fillings ☐ Deep Cleaning ☐ Gum Treatment ☐ Braces ☐ Crown/Cap ☐ Bridge ☐ Root Canal
☐ Extraction ☐ Implant ☐ Partial ☐ Denture

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Please rate your overall dental health.

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Signature _____ **Date** _____

Response Date: ___/___/_____