Kosnic & Murphy Dental

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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
- ☐ *Pre-Med-Cephalexin
- ☐ Allergy - Amoxicilin
- ☐ Allergy - Aspirin
- ☐ Allergy - Carbocaine
- ☐ Allergy - Codeine
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy - Tetracycli
- ☐ Allergy - Vicodin
- ☐ Allergy-Acetaminophe
- ☐ Allergy-Clindamycin
- ☐ Allergy-Erythromycin
- ☐ Allergy-Tetracycline
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Auto Immune Disease
- ☐ Blood Disease
- ☐ Blood thinner
- ☐ Cancer
- ☐ Carbocaine - Use
- ☐ Chemo/Radiation
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Epinepherine Reactio
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Heart Issues
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ History Blood Clot
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Oral Cancer
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ PREMED FOR LIFE
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Prob/Ulcers
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Wears C-pap
- ☐ Wears Snore Guard

*

- ☐ 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 (INCLUDING VITAMINS AND SUPPLEMENTS)

____

____

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: ____________