WEST PEAKS
DENTAL SUITE

1. When was your last medical check-up? _____ ***Name of Physician?*** _____

2. Have you experienced excessive weight gain or loss recently? Yes No

3. Women: Are you currently pregnant or breast feeding? Yes No

4. Have you been hospitalized previously? Reason _____

5. Have you ever been diagnosed or treated for any of the following conditions?

Heart Problems

	Yes	No
1. Heart failure	☐	☐
2. Heart disease	☐	☐
3. Heart Murmur	☐	☐
4. Angina pectoralis or chest pain	☐	☐
5. Heart attack	☐	☐
6. High blood pressure	☐	☐
7. Low blood pressure	☐	☐
8. Rheumatic fever	☐	☐
9. Mitral valve prolapse	☐	☐
10. Arrhythmia	☐	☐
11. Stroke	☐	☐
12. Congenital heart defect	☐	☐

Blood Disorders

13. Hemophilia	☐	☐
14. Anemia	☐	☐
15. Leukemia	☐	☐
16. Prolonged bleeding	☐	☐

Breathing & Lung Problems

17. Hay fever	☐	☐
18. Sinus problems	☐	☐
19. Tuberculosis	☐	☐
20. Asthma	☐	☐
21. Chronic Obstructive Pulmonary Disease	☐	☐
22. Emphysema	☐	☐

Digestive Problems

23. Crohn's disease	☐	☐
24. Ulcerative colitis	☐	☐
25. Celiac disease	☐	☐
26. Kidney disease	☐	☐

	Yes	No
27. G.E.R.D. (Gastro-esophageal reflux disease)	☐	☐
28. Liver disease	☐	☐
29. Stomach or duodenal ulcers	☐	☐

Metabolic Disorders

30. High cholesterol	☐	☐
31. Diabetes	☐	☐
32. Hyperthyroidism	☐	☐
33. Osteoporosis	☐	☐
34. Hormone deficiency	☐	☐
35. Addison's disease	☐	☐
36. Cushing's disease	☐	☐

Viral Ailments

37. Hepatitis A B C ____	☐	☐
38. AIDS/HIV	☐	☐
39. Cold sores	☐	☐

Other Conditions

40. Epilepsy	☐	☐
41. Malignant hyperthe-rmia	☐	☐
42. Arthritis	☐	☐
43. Glaucoma	☐	☐
44. Frequent headaches	☐	☐
45. Fibromyalgia	☐	☐
46. Bulimia/Anorexia	☐	☐
47. Cancer	☐	☐
48. Substance abuse	☐	☐
49. Current smoker	☐	☐
50. Hearing impairment	☐	☐
51. Psychiatric condition	☐	☐

6. Have you ever experienced a reaction to, or are aware of an existing allergy to any of the following?

	Yes	No
a. Metals (gold, silver, nickel) _____	☐	☐
b. Local anesthetics or general anesthetics _____	☐	☐
c. Latex _____	☐	☐
d. Aspirin, acetaminophen, ibuprophen _____	☐	☐
e. Tetracycline _____	☐	☐
f. Fluoride _____	☐	☐
g. Penicillin _____	☐	☐
h. Codeine _____	☐	☐
i. Sulfa based medications _____	☐	☐
j. Known allergy to other medications: (please list)	☐	☐

_____

7. Are you currently taking any of the following medications?

	Yes	No
a. Bisphosphonates (Fosamax, Didrocal, Actonel, Aclasta or Fosavance) _____	☐	☐
b. High blood pressure medication _____	☐	☐
c. Antidepressant medications _____	☐	☐
d. Steroid or corticosteroids (Including prednisone)	☐	☐
e. Nitroglycerine _____	☐	☐
f. Dilantin or anticonvulsants _____	☐	☐
g. Blood thinner (Plavix, Heparin, Coumadin, Warfarin)	☐	☐
h. Birth control pill _____	☐	☐
i. Insulin, Metformin, Tolbutamide _____	☐	☐
j. Tranquilizers _____	☐	☐
k. Antibiotics _____	☐	☐
i. Please List Medications:	☐	☐

_____

_____

8. Have you or are you currently undergoing any of the following medical procedures?

	Yes	No
a. Artificial joint replacement _____	☐	☐
b. Artificial heart valve placement _____	☐	☐
c. Organ transplant _____	☐	☐
d. Chemotherapy for cancer _____	☐	☐
e. Radiation therapy for cancer _____	☐	☐
f. Blood transfusion _____	☐	☐
g. Dialysis _____	☐	☐
h. Pacemaker or defibrillator _____	☐	☐

11. Are there any medical conditions not listed here that you have been diagnosed or treated for?

_____

To the best of my knowledge, all of the information provided above is true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medications or medical status change, I will inform the dentist at my next dental visit.

_____ _____ _____

Date ***Name*** *(Patient, Parent or Legal Guardian)* ***Signature*** *(Patient, Parent or Legal Guardian)*

_____ _____ _____

Date *Reviewed By (Office Use Only)* *Reviewers Signature (Office Use Only)*

WEST PEAKS
DENTAL SUITE

Name:	Age:____ Sex:____ Date of Birth (DD/MM/YR) ____/____/____
Address	Postal Code
Preferred Phone Number	Alternate Phone Number
Emergency Contact	Phone number
Primary Dental Insurance	Group/Policy# ID#
Secondary Dental Insurance	Group/Policy# ID#
Secondary Policy Holders Name	Date of Birth (DD/MM/YR) ____/____/____
How did you hear about our office?	

Please let us know how you would like us to communicate by checking the box and providing contact information.

- ☐ Text message (Please provide if other than preferred number):_____
- ☐ Email:_____
- ☐ Phone call or voice message at preferred number (Please provide if different than preferred number): _____

		Yes	No
Personal Dental History			
1.	Are you fearful of dental treatment?	☐	☐
2.	*Have you had an unfavorable dental experience?*	☐	☐
3.	*Have you ever had complications following dental treatment?*	☐	☐
4.	*Do you have trouble getting numb or have had reactions to dental anesthetics?*	☐	☐
5.	*Have you had teeth removed in the past?*	☐	☐
Smile characteristics			
6.	*Is there anything about the appearance of your teeth that you would like changed?*	☐	☐
7.	*Have you ever bleached your teeth?*	☐	☐
8.	*Are you self conscious about your teeth or smile?*	☐	☐
9.	*Have you been disappointed with the appearance of past dental work?*	☐	☐
Bite and Jaw Joint			
10.	*Do you or would you have difficulty chewing gum?*	☐	☐
11.	*Do you or would you experience difficulties chewing bagels or other hard foods?*	☐	☐
12.	*Have your teeth become shorter, thinner or worn over the last 5 years?*	☐	☐
13.	*Have your teeth become crowded or developed spaces between them in the last 5 years?*	☐	☐
14.	*Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?*	☐	☐
15.	*Do you have troubles sleeping or wake up with an awareness of your teeth?*	☐	☐
16.	*Do you or have you experienced problems with your jaw joint? (pain, clicking, popping, sounds)*	☐	☐
17.	*Has your jaw ever locked open or shut?*	☐	☐
18.	*Have you ever worn a bite appliance or night guard?*	☐	☐
19.	*Do you experience frequent tension headaches or sore teeth?*	☐	☐
Tooth Structure			
20.	*Have you had a cavity within the last two years?*	☐	☐
21.	*Do you experience a dry mouth?*	☐	☐
22.	*Are your teeth sensitive to hot, cold or sweets?*	☐	☐
23.	*Have you ever had a cracked tooth and/or filling, toothache or broken tooth?*	☐	☐
24.	*Do you avoid brushing or eating in any particular part of the mouth?*	☐	☐
Gum and Bone			
25.	*Have you ever been diagnosed with or treated for periodontal (gum) disease?*	☐	☐
26.	*Have you experienced gum recession?*	☐	☐
27.	*Do your gums bleed when you floss or brush?*	☐	☐
28.	*Is there a history of anyone in your immediate family with early tooth loss or periodontal disease?*	☐	☐
29.	*Are your teeth becoming loose?*	☐	☐
30.	*Have you ever noticed or experienced an unpleasant odor or taste in your mouth?*	☐	☐