Baker Dental, P.C.
DENTAL & HEALTH HISTORY

Name ____ Date ______________________________

Date of last health care exam: ________________What was this exam for?__________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:____

Are you currently receiving care? No Yes If yes, nature of care: __________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____
4. ____

For the following questions circle yes or no.

Do your gums bleed when you brush or floss?	No	Yes	Do you have any clicking, popping or discomfort in the jaw?	No	Yes
Are your teeth sensitive to hot, cold, sweet or pressure	No	Yes	Do you grind your teeth?	No	Yes
Have you had any Periodontal treatment?	No	Yes	Do you have denture or partials?	No	Yes
Have you had any Orthodontic treatment?	No	Yes	Is your mouth dry?	No	Yes
Do you have earaches or neck pain?	No	Yes	Other:	No	Yes

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemo. Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Thyroid Problems	No	Yes
Congestive Heart Failure	No	Yes	Recurrent Illnesses	No	Yes
Heart Murmur	No	Yes	Reflux/ Persistent Heartburn	No	Yes
Mitral Valve Prolapse	No	Yes	Ulcers	No	Yes
Rheumatic Heart Disease	No	Yes	Pacemaker	No	Yes
Stroke if yes please give date	No	Yes	Other conditions	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

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Please list any medications or dietary / herbal supplements you are currently taking with dosages and for what purpose:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________
7. ______________________________ 8. ______________________________

Women: Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes

Abnormal Blood Pressure? (Please circle) No Yes

Have you ever received a diagnosis of "high or low blood pressure"?

What is your normal blood pressure? S /D Today: __________/________

Are you allergic or have you had a reaction to:

a.	Local anesthetics ………………………………………………………...	No	Yes
b.	Penicillin or other antibiotics ……………………………………………	No	Yes
c.	Aspirin, Ibuprofen or Tylenol …..………………………………………	No	Yes
d.	Codeine, Valium® or other sedatives……………………………………	No	Yes
e.	Latex or Metals		
f.	Other (please specify)______________________________		

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

____

____

Significant findings from questionnaire or oral interview:

____

____

Dental management considerations:

____

____

Weight and Diet considerations **(for conscious sedation & Anxiolysis patients only)**

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none* *slight* *moderate* *high*			

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

______________________ ______________________ ______________

Patient (Print Name) *Patient Signature* *Date*

______________________ ______________________ ______________

Doctor or Hygienist (Print Name) *Doctor or Hygienist Signature* *Date*

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