cabrillo dental

FAMILY AND COSMETIC DENTISTRY

Everything you need for a healthy smile

PATIENT INFORMATION FORM – SECTION 2

PLEASE FILL OUT THIS FORM COMPLETELY

5 *Medical History*

Your current physical condition ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one ____________________

Have you ever taken Bisphosphonates? ☐ Yes ☐ No

(Known as Fosamax, Actonel, etc.) if yes, when? ____________

FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

- Y ☐ Abnormal Bleeding
- Y ☐ Alcohol/Drug Abuse
- Y ☐ Anemia
- Y ☐ Arthritis
- Y ☐ Artificial Bones, Joints or Valves
- Y ☐ Asthma
- Y ☐ Blood Transfusion
- Y ☐ Cancer/Chemotherapy
- Y ☐ Colitis
- Y ☐ Congenital Heart Defect
- Y ☐ Diabetes
- Y ☐ Difficulty Breathing
- Y ☐ Emphysema
- Y ☐ Epilepsy
- Y ☐ Fainting Spells
- Y ☐ Frequent Headaches
- Y ☐ Glaucoma
- Y ☐ Heart Attack
- Y ☐ Heart Surgery
- Y ☐ Hemophelia
- Y ☐ Hepatitis
- Y ☐ Herpes/Fever Blisters
- Y ☐ High Blood Pressure
- Y ☐ HIV+/AIDS
- Y ☐ Kidney Problems
- Y ☐ Liver Disease
- Y ☐ Lupus
- Y ☐ Osteoporosis
- Y ☐ Pacemaker
- Y ☐ Psychiatric Care
- Y ☐ Radiation Treatment
- Y ☐ Seizures
- Y ☐ Sickle Cell Disease
- Y ☐ Sinus Problems
- Y ☐ Stroke
- Y ☐ Thyroid Problems
- Y ☐ Tuberculosis (TB)
- Y ☐ Ulcers
- Y ☐ Venereal Disease

Please list any medical condition not mentioned above:

____

Have you ever been hospitalized for any reason? List why:

____

____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Y ☐ Aspirin
- Y ☐ Codeine
- Y ☐ Dental Anesthetics
- Y ☐ Erythromycin
- Y ☐ Jewelry/Metals
- Y ☐ Latex
- Y ☐ Penicillin
- Y ☐ Terracycline

Please list any allergies not mentioned above:

____

6 *Medical Information*

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________________

____

Physician's Name ____________________

Phone # ____________ Last Visit ____________

IN THE CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name ____________ Relation ____________

Home # ____________ Work # ____________

7 *Dental History*

Why have you come to the dentist today? ____________

____

Has your doctor told you that you require antibiotics before dental treatment? Yes ☐ No ☐

Are you currently in pain? Yes ☐ No ☐

Have you ever had a serious/difficult problem associated with any previous dental work? Yes ☐ No ☐

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes ☐ No ☐

Your Current dental health is? Good ☐ Fair ☐ Poor ☐

Do you like your smile? Yes ☐ No ☐

Do your gums ever bleed? Yes ☐ No ☐

How many times a week do you use floss?

How many times a day do you brush?

Type of toothbrush bristles? ☐ Hard ☐ Medium ☐ Soft