

MEDICAL INFORMATION (CONTINUED)

YES/NO

- Are you in good health?
 Are you currently under the care of a physician?

Physician Information: Please list all medical specialist that you see at least once a year. (Please print)

NAME	ADDRESS/CITY	PHONE NUMBER	NAME OF SPECIALTY

- Are you taking or have recently taken any prescription or over the counter medicines?
 If YES, please list. _____
- Do you regularly take herbal medications or dietary supplements?
 Specifically, do you take (circle all that apply): Echinacea/Feverfew/Garlic/Ginger/Ginko/Ginseng/Kava/St. John's Wort/Valerian/Vitamin E
- Have you ever taken weight loss medication? If YES, have you taken the following? (circle all that apply): Fen-phen/Pondimen/Redux/Other
- Have you undergone current or past osteoporosis therapy? (Examples are: Fosamax/Actonel/Boniva pill form)
- Have you undergone current or past therapy to reduce high blood calcium? (Examples are intravenous Aredia, Zometa)
- Are you or have you ever been addicted to a chemical substance? (Example: alcohol, prescription drugs, heroin, meth, cocaine, other)
- Do you currently drink alcohol or recreational drugs?
- Do you smoke or use smokeless tobacco?
 If YES, what type of tobacco do you use? _____ How interested are you in quitting? Very Interested/Interested/Not Interested?
- Has there been any changes in your general health within the past year?
- Have you had a serious illness, operation or been hospitalized in the past five years?
 If YES, please list: _____

Please mark a (√) to indicate if you have or have not ever had any of the following diseases/problems listed in the columns below.

YES/NO

YES/NO

YES/NO

- | | | |
|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> <input type="checkbox"/> Allergies/Hay Fever/Hives | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> <input type="checkbox"/> Recent weight Loss |
| <input type="checkbox"/> <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> <input type="checkbox"/> Recurrent Infections |
| <input type="checkbox"/> <input type="checkbox"/> Anemia/ Blood Disease | <input type="checkbox"/> <input type="checkbox"/> Fainting Spells/ Dizziness | <input type="checkbox"/> <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> <input type="checkbox"/> Angina | <input type="checkbox"/> <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> <input type="checkbox"/> Rash |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur/Irregular Heart Beat | <input type="checkbox"/> <input type="checkbox"/> Sleeping Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Shingles |
| <input type="checkbox"/> <input type="checkbox"/> Cancer/ Leukemia | <input type="checkbox"/> <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy/ Radiation | <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pains | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> <input type="checkbox"/> Cold Sores/ Fever Blisters | <input type="checkbox"/> <input type="checkbox"/> Hemophilia/Bleeding Problems | <input type="checkbox"/> <input type="checkbox"/> SLE (Lupus) |
| <input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A, B or C (circle type) | <input type="checkbox"/> <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> <input type="checkbox"/> Herpes | <input type="checkbox"/> <input type="checkbox"/> Steroid Therapy |
| <input type="checkbox"/> <input type="checkbox"/> Chronic/ Frequent Cough | <input type="checkbox"/> <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Convulsions | <input type="checkbox"/> <input type="checkbox"/> Impairment of Speech/Sight/Hearing | <input type="checkbox"/> <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Liver Disease/Yellow Jaundice | <input type="checkbox"/> <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> <input type="checkbox"/> Damage Heart Valve | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Easily Winded | <input type="checkbox"/> <input type="checkbox"/> Pain in jaws or joints | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |

Please complete the Health History Form and then sign below:

Kennedy Dental LLC request this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside of the Kennedy Dental office will be provided this information unless authorized by you or required by law. Failure to provide the request information will limit the ability to access your needs and may result in Kennedy Dental being unable to accept you as a patient. By signing below, you agree that this information given is accurate and that you will notify Kennedy Dental LLC at subsequent appointments if there are changes in your health.

Patient/ Guardian Signature: _____ Date: _____

Dentist Signature & Date: _____ Date: _____

Patient Name: _____



Welcome! So that we may provide you with the best possible care.
Please complete both sides of this dental/ medical history form.
All information is completely confidential.

DENTAL INFORMATION

What is the reason you are seeking dental care? _____

Please list your PREVIOUS dental provider below:

(Name)	(Address)	(Phone Number)

Date of your: last: dental cleaning & exam _____ Full mouth series of x-rays _____

Please answer the following questions by marking an (✓) in the columns provided below

<p><u>YES/NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Are you happy with your smile?</p> <p><input type="checkbox"/> <input type="checkbox"/> Would you like your teeth to be whiter?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are your teeth sensitive to hot/ cold/ sweets/ pressure?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do your gums bleed when you brush or floss?</p> <p><input type="checkbox"/> <input type="checkbox"/> Does food/ floss get caught between your teeth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Is your mouth dry?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you get sores or ulcers in your mouth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you participate in recreational activities?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you wear a mouth guard?</p>	<p><u>YES/NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had a serious injury to your mouth or head?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have earaches, headaches, neck pain?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you drink bottled water or filtered water?</p> <p><input type="checkbox"/> <input type="checkbox"/> Is your water supply fluoridated?</p> <p><input type="checkbox"/> <input type="checkbox"/> Has fear or an upsetting dental experience kept you from seeking dental care?</p> <p>Indicate YES to <u>treatment that you experienced</u> by marking on (✓) in the boxes below.</p> <p><input type="checkbox"/> TMJ/ Bite Splint Therapy <input type="checkbox"/> Denture/ Partial <input type="checkbox"/> Root Canal</p> <p><input type="checkbox"/> Periodontal (gum) treatment <input type="checkbox"/> Orthodontics (braces) <input type="checkbox"/> Crown</p> <p><input type="checkbox"/> Fillings <input type="checkbox"/> Implant</p>
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MEDICAL INFORMATION

Allergies: Please indicate NO/ YES to any previous reactions to items below. To all YES responses, SPECIFY TYPE OF REACTION.

<p><u>YES/NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Local anesthetics _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Penicillin _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other antibiotics _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs _____</p>	<p><u>YES/NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Codeine Drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Latex (rubber) _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Aspirin _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Metals _____</p>	<p><u>YES/NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Acrylic</p> <p><input type="checkbox"/> <input type="checkbox"/> Barbiturates, sedatives or sleeping pills _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Iodine _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p>
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Has any physician or previous dentist recommended that you take antibiotics prior to your dental treatment? YES/NO
If YES, please list: Physician/ Dentist name: _____ Phone Number: _____

Please indicate YES/NO to any diseases/problems listed in the columns below.

<p><u>YES/NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/> An artificial (prosthetic) heart valve?</p> <p><input type="checkbox"/> <input type="checkbox"/> A damaged valve in a transplanted heart?</p> <p><input type="checkbox"/> <input type="checkbox"/> A congenital heart disease (CHD)?</p> <p><input type="checkbox"/> <input type="checkbox"/> An unrepaired, cyanotic CHD?</p> <p><input type="checkbox"/> <input type="checkbox"/> A repaired (completely) in the past 6 months?</p> <p><input type="checkbox"/> <input type="checkbox"/> A repaired CHD with residual defects?</p>	<p><u>YES/NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had infected endocarditis (heart infection)?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had a total knee/hip joint replacement? If YES, when was it placed? Date: _____ If YES, have you had any complications? _____</p>
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(Please complete other side)