Patient Name:

Smile
KENNEDY DENTAL

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

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

MEDICAL INFORMATION

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

YES/NO		YES/NO		YES/NO	
□	□ Local anesthetics _____	□	□ Codeine Drugs	□	□ Acrylic
□	□ Penicillin _____	□	□ Latex (rubber) _____	□	□ Barbiturates, sedatives or sleeping pills _____
□	□ Other antibiotics _____	□	□Aspirin _____	□	□ Iodine_____
□	□ Sulfa Drugs _____	□	□ Metals _____	□	□ Other _____

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.

YES/NO		YES/NO	
□	□ An artificial (prosthetic) heart valve?	□	□ Have you had infected endocarditis (heart infection)?
□	□ A damaged valve in a transplanted heart?	□	□ Have you had a total knee/hip joint replacement?
□	□ A congenital heart disease (CHD)?		If YES, when was it placed? Date: _____
□	□ An unrepaired, cyanotic CHD?		If YES, have you had any complications? _____
□	□ A repaired (completely) in the past 6 months?		
□	□ A repaired CHD with residual defects?		

(Please complete other side)

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