Point Village Dental

44990 Heydenriech Suite E
Clinton Township, MI 48038

Medical /Dental History for:

Name: _____

Please take a moment to help us to help you by providing the following information.

Allergies to:

- ☐ Latex? Yes No
- ☐ Medications? _____
- ☐ Others? _____

PreMed Required? Yes / No

- ☐ Reason: _____
- ☐ Type: _____
- ☐ Dosage: _____

Current Medications: **(Prescription, Over the counter, and Herbal)**

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Past and Current Medical Conditions (mark all that apply)

- ☐ Under physician's care
- ☐ Hospitalization/operation in last 5 years
- ☐ Head /Neck /Mouth Injuries
- ☐ For women: Pregnant
- ☐ For women: Oral Contraceptives
- ☐ For women: Nursing
- ☐ Heart trouble/disease
- ☐ Rheumatic fever
- ☐ Past use of Fenphen
- ☐ Heart murmur
- ☐ Mitral valve prolapsed
- ☐ Heart Surgery
- ☐ Artificial Heart Valves
- ☐ Pacemaker
- ☐ Indwelling defibrillator
- ☐ Artificial joints
- ☐ History of organ transplant
- ☐ High blood pressure
- ☐ Stroke
- ☐ Bleeding problem
- ☐ Hemophilia
- ☐ Anemia
- ☐ Lung Disease
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Sinus trouble
- ☐ Cancer
- ☐ Radiation Treatment to Head/Neck
- ☐ Chemotherapy
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Eating Disorder
- ☐ Stomach: Acid Reflux
- ☐ Stomach: Ulcer
- ☐ Immunological diease
- ☐ Sjogren's Disease
- ☐ Fibromyalgia
- ☐ Other autoimmune disease: Lupus /Pemphigus
- ☐ Arthritis or joint disorders
- ☐ Diabetes Type: Controlled? Y / N
- ☐ **None of the above apply –Turn to Next Page.**

- ☐ Frequent Headaches
- ☐ Depression: Diagnosed? Y /N
- ☐ Other Psychiatric Disorders
- ☐ Neurologic Disease
- ☐ Convulsions
- ☐ Epilepsy /Seizures
- ☐ Cerebral Palsy
- ☐ Fainting / Dizziness
- ☐ STD/Venereal Disease
- ☐ AIDS/HIV positive
- ☐ Alcohol or chemical Dependency
- ☐ Hepatitis
- ☐ Thyroid Disease
- ☐ Glaucoma
- ☐ **None of the above apply**

Tobacco Use

- ☐ Type? _____
- ☐ Amount: _____
- ☐ Number of Years: _____
- ☐ Number of attempts to quit? _____
- ☐ Methods Used: _____
- ☐ Former Tobacco User? Y / N
  Year Quit: _____

Dental Information:

Previous dentist: _____
How long since last dental visit: _____
How long since last cleaning: _____
Frequency of Dental Exams: _____
Frequency of brushing: _____
Frequency of flossing: _____
What are some typical foods you eat between meals? _____
What types of beverages do you typically drink between meals? _____
How often do you chew or suck hard candy, cough drops, or mints? _____
Do you use fluoridated toothpaste? Y / N
Primary source of drinking water?

- ☐ City
- ☐ Bottled
- ☐ Well

Are you nervous about dental treatment? Y / N

What can we do to make your experience better?
_____
_____
_____
_____

What made you decide to make this dentist appointment?
_____
_____

Do you have consistent problems with:

- ☐ Dry Mouth/ Excessive thirst
- ☐ Sensitive teeth Hot / Cold / Pressure / Sweets
- ☐ Mouth Odors/ Bad taste
- ☐ Any lumps, swelling?
- ☐ Sore, bleeding gums?
- ☐ Loose teeth?
- ☐ Food catches easily between teeth?
- ☐ Clenching / Grinding Habits?
- ☐ Jaw pain
- ☐ Do you hear popping, clicking, or snapping?
- ☐ Do you wake up out of sleep due to pain?
- ☐ None of the above apply

Past Dental Treatment: (Check those that apply)

- ☐ One or more fillings in the last 3 years
- ☐ Diagnosed with Gum Disease or Periodontitis
- ☐ Family history of Gum Disease or Periodontitis
- ☐ Family history of extensive tooth decay
- ☐ Treatment for Gum Disease or Periodontitis
- ☐ Have you had Orthodontics (braces?)
- ☐ Have you had Oral Surgery?
- ☐ Have you had dental implants placed?
- ☐ Have you had treatment for TMJ Disorders?
- ☐ Do you wear Denture(s) or Partial denture (s)
- ☐ None of the above apply

Thank you for filling out the information. Additional Comments?