Time 4:10 PM

Paintbrush Dental

Paintbrush Dental Medical History

Date 7/29/2021

Patient Name:

Birth Date:

Date Created:

Your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? Who?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation? Please list.	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury? Please describe.	◯ Yes ◯ No	If yes	
Are you taking any medications? Please list.	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate medication? Please list.	◯ Yes ◯ No	If yes	
Do you use tobacco? Please state if you chew, smoke or vape.	◯ Yes ◯ No	If yes	
Do you take any blood thinners? Such as: Plavix, Warfarin, Eliquis, Heparin. Please list.	◯ Yes ◯ No	If yes	

Does any of this treatment interest you?

☐ Tooth whitening ☐ Dental implants ☐ Smile makeover (veneers) ☐ Replacement of worn fillings

☐ Sedation ☐ Dentures

Women: Are you...

☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

If pregnant, when is your due date? ☐ If yes

Do you have:

☐ Missing teeth ☐ Loose teeth ☐ Tooth pain

☐ Tooth sensitivity ☐ Broken or chipped teeth ☐ Pain/popping in jaw joints

☐ Oral cancer or history of ☐ Periodontal disease ☐ Cold sores/fever blisters

☐ Fear of dentist/treatment ☐ Previous bad dental experience ☐ Fear of needles

☐ Receding gums ☐ Grinding or clenching ☐ Frequent vomiting

☐ Acid reflux ☐ Decay/cavities ☐ Bleeding gums

☐ Dry mouth ☐ History of mouth/facial trauma ☐ Bad breath

Do you wear partial or full dentures? If yes, do you....

☐ Use adhesive ☐ Have trouble chewing ☐ Have digestion problems

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex

☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have or have you had any of the following?

Chemo/Radiation Treatments ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A, B OR C ◯ Yes ◯ No
Recent Weight Loss ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No
Sickle Cell Disease ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No
Stomach/Intestinal Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No
Stroke ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No
Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No
Osteoporosis ◯ Yes ◯ No	Active tuberculosis ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Epilepsy or seizures ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Hearing loss ◯ Yes ◯ No
AIDS/HIV positive ◯ Yes ◯ No	Vertigo ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? If so, please list. ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____