

**PREHN DENTAL OFFICE
PATIENT MEDICAL HISTORY**

PATIENT NAME: _____ DATE: _____

FAMILY PHYSICIAN: _____ ANY SPECIALIST?: _____

Do we have your permission to contact your personal physician if the need arises?

Yes _____ No _____

Are you currently under a Medical Doctors care for a physical condition? Yes _____ No _____

Please explain: _____

Pharmacy: _____

<p>List All Medications: Non-Prescription & Prescription</p>	<p align="center">Allergies:</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center; width: 33%;">Y N</td> <td style="text-align: center; width: 33%;">Y N</td> <td style="text-align: center; width: 33%;">Y N</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> <input type="checkbox"/> Erythromycin</td> <td><input type="checkbox"/> <input type="checkbox"/> Metals</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Codeine</td> <td><input type="checkbox"/> <input type="checkbox"/> Jewelry</td> <td><input type="checkbox"/> <input type="checkbox"/> Penicillin</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics</td> <td><input type="checkbox"/> <input type="checkbox"/> Latex</td> <td><input type="checkbox"/> <input type="checkbox"/> Tetracycline</td> </tr> </table> <p>Other: _____ _____</p>	Y N	Y N	Y N	<input type="checkbox"/> <input type="checkbox"/> Aspirin	<input type="checkbox"/> <input type="checkbox"/> Erythromycin	<input type="checkbox"/> <input type="checkbox"/> Metals	<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Jewelry	<input type="checkbox"/> <input type="checkbox"/> Penicillin	<input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> <input type="checkbox"/> Latex	<input type="checkbox"/> <input type="checkbox"/> Tetracycline
Y N	Y N	Y N											
<input type="checkbox"/> <input type="checkbox"/> Aspirin	<input type="checkbox"/> <input type="checkbox"/> Erythromycin	<input type="checkbox"/> <input type="checkbox"/> Metals											
<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Jewelry	<input type="checkbox"/> <input type="checkbox"/> Penicillin											
<input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> <input type="checkbox"/> Latex	<input type="checkbox"/> <input type="checkbox"/> Tetracycline											
<p align="center">Miscellaneous:</p> <p>Y N <input type="checkbox"/> <input type="checkbox"/> Do You Smoke or Use Tobacco?</p> <p>Height: _____' _____" Weight: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you lost/gained more than 10 lbs. in the past year?</p>	<p align="center">For Women Only:</p> <p>Y N <input type="checkbox"/> <input type="checkbox"/> Are you taking birth control pills?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you pregnant? # of weeks _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you nursing?</p> <hr/> <p>Office Use: BP _____ / _____ Heart Rate: _____</p>												

Conditions: Please check Yes or No to the Following

<p>Y N <input type="checkbox"/> <input type="checkbox"/> B/4 Dental Appts Do You Premedicate?</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> <input type="checkbox"/> Coumadin</p>	<p>Y N <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia/Blood Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Joint</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis A</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p>	<p>Y N <input type="checkbox"/> <input type="checkbox"/> Herpes (Any Kind)</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever Blisters/ Cold Sores</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Malignant Hyperthermia</p> <p><input type="checkbox"/> <input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol/Drug Abuse</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric/Emotional Care</p> <p><input type="checkbox"/> <input type="checkbox"/> Respiratory Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p>	<p>Y N <input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumocystitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers/Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiation/Chemotherapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Tonsils/Adnoids Removed</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye/Ear Disorder</p>	<p>Y N <input type="checkbox"/> <input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep Apnea/Excessive Snoring</p> <p><input type="checkbox"/> <input type="checkbox"/> TMJ/TMD Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis/Rheumatism</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting/Dizzy Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Do You Take Herbs/Vitamins?</p>
---	---	--	--	---

I attest these answers to be truthful and as complete as possible.

Signature: _____ **Date:** _____

PLEASE COMPLETE THE BACK OF THIS FORM

PREHN DENTAL OFFICE

DENTAL INFORMATION

NAME: _____ DATE: _____

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE NOW OR MAY HAVE HAD IN THE PAST:

Bleeding Gums
Swelling or Lumps in Mouth
Clenching or Grinding Teeth
Blisters/Sores on Lips or Mouth
Oral Habits, e.g. fingernail biting
Unfavorable Dental Experience
Extensive Crown and Bridge-work

Bad Breath
Periodontal Treatment
Orthodontic Treatment
Mouth Breathing
Complications from Oral Surgery
Pain or Unusual sounds in Jaw, Joints, or Ear

CIRCLE ANY OF THE FOLLOWING THAT YOU USE:

Cigarettes, pipe, cigars _____ per day
Chewing tobacco
Pop and/or Juice intake _____ per day

Dental Floss _____ x/week
Water Jet Device
Fluoride Supplements or Rinse
Brush your teeth _____ x/day

Do you prefer anesthetics? No _____ Yes _____ Do you prefer Nitrous Oxide (laughing gas)? No _____ Yes _____

At present, do you have any dental concerns? _____

Have you experienced trauma to the jaw? No _____ Yes _____
(Explain) _____

Have you had orthodontic treatment (braces)? No _____ Yes _____ Year _____

How long do you expect to keep your teeth? _____

What prompted you to seek dental care at this time? _____

Is there anything in your past dental history I should know about? No _____ Yes _____ (Explain) _____

Are you satisfied with your past dental care? _____

Date of last teeth cleaning: _____ Date of last dental x-rays: _____

Do you like the way your teeth look when you smile? No _____ Yes _____

What would you change about your smile if you answered "No" to the above question? _____

Are you interested in learning how to enhance your smile through shaping, veneers, bonding, bleaching, orthodontics?
No _____ Yes _____

Are you aware Prehn Dental Office offers an at-home bleaching system and how it can make a difference in your smile?
No _____ Yes _____

Have any teeth been injured due to accidents or falls? _____ Explain: _____