Platinum Dental, Inc.

Medical and Dental Health History

Name of Medical Doctor: _____ City: _____ Phone: ( )_____

Date of last medical Exam: _____ *(Women only)* Is there any possibility you are pregnant? No □ Yes □ ____Months

Have you even had or do you have any of the following? Please check below.

□ Heart murmur
□ Rheumatic fever
□ Mitral Valve Prolapse
□ Prosthetic joints / Heart Valves
□ Pacemaker
□ Heart problems: _____
□ High Blood Pressure
□ Stroke, when: _____
□ Blood trouble, anemia, leukemia
□ Excessive bleeding
□ Hepatitis: A or B or C or other
□ Diabetes: Type I or Type II
□ Tired jaw muscles
□ Dizziness/Loss of Balance
□ Earaches
□ Ringing in ears
□ Ear stuffiness
□ Jaw pain
□ Neck pain
□ Headaches/Facial Pain
□ Clenching/Grinding
□ Change in bite
□ Jaw locking/catching
□ Jaw clicking/popping
□ Lung trouble (TB, asthma, emphysema)
□ Kidney disease: _____
□ Arthritis, Degenerative joint disease
□ Fainting spells, epilepsy, convulsions
□ Nervous breakdown/ anxiety disorders
□ Indium, cobalt or Lithium treatment
□ Radiation or chemotherapy
□ Tumor or cancer
□ Shortness of Breath
□ Venereal disease
□ AIDS related complex
□ Other: _____

Are you now taking medicines for: (please specify medication)

□ Pain _____ □ Heart _____
□ Headaches _____ □ Nerves _____
□ Arthritis _____ □ Sleeping _____
□ Allergy (asthma) _____ □ Blood (thinners)_____
□ Stomach (ulcers) _____ □ GERD _____
□ Thyroid _____ □ Birth Control _____
□ Other _____

Have you ever been <u>allergic</u> to, been sick from, or been told not to take:

□ Latex: _____
□ Metals: _____
□ Antibiotics (Penicillin, other): _____
□ Narcotics (Codeine, other): _____
□ Aspirin, NSAIDS: _____
□ Anesthetics (Novocaine, other): _____
□ Other medications: _____

Do you have any disease conditions, or problems that are not mentioned above? _____
Do you smoke? No □ Yes □ **If yes, how many cigarettes a day?** _____ **How many years?** _____
Have you ever taken the diet drug combination, Fen-Phen? No □ Yes □ other **diet drugs?** _____

Previous Dentist's Name:_____ City:_____

Reason for leaving previous dentist:_____

Have you ever had or do you have any of the following?

□ Orthodontic treatment _____
□ Dental extractions _____
□ Periodontal treatment _____
□ Gum surgery _____
□ Dental implants _____
□ Gum disease _____
□ Endodontics/Root canals _____
□ Mouth guards/Sports guards_____
□ Night guards _____
□ Teeth whitening _____
□ Sleep dentistry/general anesthesia/laughing gas
□ Fear or anxiety related to dental treatment

What is the reason you are seeking dental care now?

□ General Check up
□ TMJ
□ Orthodontics/Invisalign
□ Whitening
□ Improve your smile/teeth
□ Reconstruction of the mouth
□ Tooth pain
□ Other: _____

Do your gums bleed when you brush or floss? □ Yes □ No
How would you rate your previous experiences at the dentist?
□ Excellent □ Good □ Average □ Painful/frightening

What has prevented you from getting quality dental care in the past? □ Money □ Pain/fear □ No interest/need □ Not applicable
□ Other: _____

I, the undersigned, have given the above information, have reviewed it and find it accurate. If there are any later changes, I will so inform the practice.
Patient Signature: _____Date: _____

Patient Name (please print): _____