Metuchen Dentistry
652 Middlesex Ave
Metuchen, NJ, 08840
Phone: (732) 603-0030
Fax: (732) 603-8255

PATIENT DENTAL AND MEDICAL HEALTH HISTORY INFORMATION

Patient Name: _____ Patient DOB: _____

DENTAL HISTORY & SYMPTOMS

1) What is the reason for your visit today? _____
2) Are you currently in any dental pain or discomfort? If yes, please specify where.

_____

3) When was your last dental exam? _____
4) When did you have your last dental radiographs taken? _____

Please mark the boxes that apply to you.

_ Is it hard to open your mouth?
_ Does it hurt to chew, bite, or swallow?
_ Do your gums bleed when you brush or floss your teeth?
_ Have you ever had any periodontal therapy like scaling and root planing?
_ Do you have, or have you ever had, any sores or growths in your mouth?
_ Do you clench or grind your teeth?
_ Does you jaw click, pop, or hurt?
_ Do you have earaches or neck pains?
_ Does dental treatment make you nervous?
_ Have you ever experienced any of the following sleep-related breathing disorders? Mouth breathing, Snoring, or Trouble Breathing during Sleep

_ Have you ever had a serious injury to your head or mouth? If yes, please describe:
_____
_ Have you ever had a reaction to or a problem with dental anesthesia? If yes, please describe:
_____
_ Have you ever had problems with dental treatment in the past? If yes, please describe:
_____
_ Are you unhappy with your smile? If yes, please specify:
_____

MEDICAL & SURGICAL HISTORY

Last Physical Exam: _____
Physician Name: _____ Physician Phone: _____
Physician Address: _____

Please mark your answers to the following questions.

	YES	NO
1) Are you in good physical health?	_	_
2) Are you currently being seen or treated by a physician?	_	_
3) Have you been recommended to take antibiotics before dental treatment?	_	_
4) Have you has a serious illness, operation, or been hospitalized in the past 5 years?	_	_
5) Have you had any joint replacement surgery?	_	_
6) Have you had an organ or bone marrow/stem cell transplant?	_	_
7) Are you taking Blood Thinners (Coumadin, Warfarin, Rivaroxabin, Dabigatran, Clopidogrel, Heparin, Aspirin, etc.) Please Specify Medication(s): _____	_	_
8) Are you taking any medication to treat Osteoporosis or Paget's disease (Alendronate, Risedronate, Ibandronate, Zolendronate, Denosumab, etc.)	_	_

Please Specify Medication(s): _____

9) Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? _ _
Please Specify Medication(s): _____

10) Do you use any form of tobacco or nicotine product? _ _
If yes, please specify: _____

11) Do you use controlled substances, for either medicinal or recreational reasons? _ _
If yes, please specify: _____

For women only:

12) Are you pregnant? If yes, number of weeks: _____ _ _

13) Are you nursing? If yes, number of weeks: _____ _ _

Have you ever had any of the following? Please check those that apply:

Cardiac Health

_ Pacemaker/implanted defibrillator
_ Artificial heart valve
_ Previous infective endocarditis
_ Congenital Heart Disease
_ Arteriosclerosis
_ Coronary Artery Disease
_ Congestive Heart Failure
_ Heart Attack
_ Heart Murmur
_ Rheumatic Heart Disease
_ Stroke

Respiratory Health

_ Asthma (COPD)
_ Bronchitis
_ Emphysema
_ Sinus trouble
_ Tuberculosis

Digestive Health

_ Gastrointestinal Disease
_ GERD/Heartburn
_ Stomach Ulcers

Circulatory Health

_ Anemia
_ Blood Transfusion (Date: _____)
_ Hemophilia
_ High Blood Pressure
_ Low Blood Pressure

Mental Health

_ Anxiety
_ Depression
_ Epilepsy
_ Mental Health Disorders
_ Neurological Disorders
_ Post-traumatic Stress Disorder
_ Traumatic Brain Injury or Concussion

Autoimmune Disease

_ AIDS/HIV
_ Lupus

Vision Health

_ Glaucoma

Other

_ Arthritis
_ Chronic Pain
_ Diabetes Type I
_ Diabetes Type II
_ Eating Disorder
_ Frequent Infections
_ Hepatitis, Jaundice, Liver Disease
_ Immune Deficiency
_ Kidney Problems/Disease
_ Malnutrition
_ Osteoporosis
_ Sexually Transmitted Diseases
_ Thyroid Condition
_ Cancer
Type: _____
Date of Diagnosis: _____
Chemotherapy: _____
Radiation Therapy: _____

Please list any allergies:

Please list all medications:

_____ DATE: _____ /_____/_____

SIGNATURE OF PATIENT/PARENT (IF PATIENT IS A MINOR, PLEASE PRINT CHILD'S NAME NEXT TO SIGNATURE)