2525 South Wadsworth Blvd. #23
Lakewood CO 80227

(303)985-0909
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Mark Granger, D.D.S.

www.toothmansion.com

Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Why are you here today?

- ☐ Toothache
- ☐ Pain or swelling
- ☐ Cavities
- ☐ Checkup and cleaning
- ☐ Dentures
- ☐ Wisdom Teeth
- ☐ Implants
- ☐ Cosemetics
- ☐ Consultation

If you have dental anxiety how would you rate this? "0" being no anxiety to "10" being very fearful.

Would you consider yourself to be in fairly good health?

○ Yes ○ No

Within the past year, have there been any changes in your general health?

○ Yes ○ No

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following medical or dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized or had an emergency room visit within the last 5 years?
- ☐ Do you require the use of corrective lenses (contacts or glasses)) or hearing aids?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

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If any of the previous questions are marked, please explain:

Please indicate if you have experienced any of the following:

- [ ] Acid Reflux
- [ ] AIDS/HIV
- [ ] Allergies
- [ ] Amoxicillin Allergy
- [ ] Anemia
- [ ] Angina/Chest Pain
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] CHF/Heart Failure
- [ ] Codeine Allergy
- [ ] Diabetes
- [ ] Dizziness
- [ ] Eating Disorder
- [ ] Emphysema
- [ ] Endocarditis
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Hearing Aid
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Surgery
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Irregular Heart Beat
- [ ] Kidney Disease
- [ ] Latex Allergy
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] MetabisulfiteAllergy
- [ ] Migraines/Headaches
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] Oral Contraceptives
- [ ] Pacemaker
- [ ] Pain in Jaw Joints
- [ ] Penicillin Allergy
- [ ] Premed Amoxicillin
- [ ] Psychiatric Therapy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Shortness of Breath
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Drug Allergy
- [ ] Swollen Ankles
- [ ] Thyroid Condition
- [ ] Tobacco Use
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Tylenol Allergy
- [ ] Ulcers/Colitis
- [ ] Venereal Disease/STD
- [ ] Yellow Jaundice

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Please list prescription and nonprescription medications. The dosages and why you are taking them? If you have a written list we can scan this into your chart.

WOMEN ONLY:

- [ ] Are you pregnant now?
- [ ] Are you trying to get pregnant or possibly be pregnant now?
- [ ] Do you practice birth control?
- [ ] Are you nursing?

If you are pregnant what is your due date?

Do you have any other health issues or allergies?

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When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please check any of the following that you use in your personal homecare routine.

☐ Electric toothbrush ☐ Sonacare toothbrush ☐ Rota-dent
☐ Toothpicks or Rotapoints ☐ Prescription fluoride gel ☐ Peridex (Chlorohexidne)
☐ Periostat ☐ Waterpik

When was the last time your teeth were cleaned?

Please mark any of the following to indicate Yes in response to the question:

☐ Do you have a current full mouth series of radiographs?
☐ Do your gums bleed when you brush or floss?
☐ Have you had periodontal treatment or gum surgery?
☐ Are any of your teeth currently causing you pain?
☐ Do your teeth experience sensitivity to cold or hot temperatures?
☐ Do ever experience sharp electrical pain when biting?
☐ Do you grind or clench your teeth (either consciously or during sleep)?