Saco River Dentistry

New Patient Health History Form

Patient Name:_____ Date of Birth:_____ Sex: ☐ Male ☐ Female
Home Phone:_____ Business/Cell Phone #:_____
E-mail:_____ SSN:_____
Address: _____
Employer:_____ Occupation:_____
Emergency contact:_____ Phone number:_____ Relationship:_____
Pharmacy: _____

How did you hear about us/Who referred you to us? _____

Dental Information

Do your gums bleed when you brush or floss? ☐ no ☐ yes
Are your teeth sensitive to cold/hot/sweets/pressure? ☐ no ☐ yes
Is your mouth dry? ☐ no ☐ yes
Currently dental pain or discomfort? ☐ no ☐ yes
Do you have earaches or neck pains? ☐ no ☐ yes
Any clicking, popping or discomfort in the jaw? ☐ no ☐ yes
Do you clench or grind your teeth? ☐ no ☐ yes
Do you have sores or ulcers in your mouth? ☐ no ☐ yes

Date of your last dental exam: _____
What is the reason for your visit today? _____
How do you feel about your smile? _____

Medical Information

1. Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ no ☐ yes: _____
2. Are you taking or have you recently taken any prescription or over the counter medications? ☐ no ☐ yes

If so, please list all and what you are taking it for:

Medication	Reason for taking

3. Do you see your primary care annually? ☐ no ☐ yes
   Name of physician: _____
   Name of physician's office/town: _____

4. Do you use controlled substances (drugs)? ☐ no ☐ yes
   Do you use tobacco? (smoking, snuff, chew, bidis)? ☐ no ☐ yes
   Have you ever had substance abuse issues involving pain medication? ☐ no ☐ yes

5. **Joint Replacement.** Have you had an orthopedic total joint replacement? ☐ no ☐ yes
   (hip, knee, elbow, finger)
   If so, which joint/ date of surgery: _____ Any complications? ☐ no ☐ yes
   Name of Orthopedic surgeon: _____
   Do you take antibiotic premed? _____

6. Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Avastin, Sutent, Nevacar, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ no ☐ yes
7. Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ no ☐ yes

Please flip over to complete health history ☺

8. WOMEN ONLY Are you Pregnant ☐ no ☐ yes Nursing? ☐ no ☐ yes

9. Allergies: Are you allergic to or have you had a reaction to:
If **yes**, specify type of reaction (eg. anaphylactic, rash, hives, swelling)

Local anesthetics…….. .☐ no ☐ yes
Aspirin…… ….☐ no ☐ yes
Penicillin or other antibiotics…… ☐ no ☐ yes
Barbiturates, sedatives, or sleeping pills…... ☐ no ☐ yes
Sulfa drugs……☐ no ☐ yes
Codeine or other narcotics……☐ no ☐ yes
Steroids…….. ☐ no ☐ yes
Other: ……☐ no ☐ yes

10. Please mark **(X)** your response if you have or have ever had any of the following diseases or problems.

Yes No
- ❑ ❑ Artificial (prosthetic) heart valve
- ❑ ❑ Previous infective endocarditis
- ❑ ❑ Damaged valves in transplanted heart
- ❑ ❑ Congenital heart disease (CHD)
  ☐ repaired ☐ unrepaired
- ❑ ❑ Cardiovascular disease
- ❑ ❑ Angina
- ❑ ❑ Arteriosclerosis
- ❑ ❑ Congenital heart failure
- ❑ ❑ Damaged heart valves
- ❑ ❑ Heart Attack Date: _____
- ❑ ❑ Heart Murmur
- ❑ ❑ Low blood pressure
- ❑ ❑ High blood pressure
  Controlled ☐ yes ☐ no
- ❑ ❑ Other congenital heart defects
- ❑ ❑ Mitral Valve Prolapse
- ❑ ❑ Pacemaker
- ❑ ❑ Rheumatic fever

Yes No
- ❑ ❑ Rheumatic heart disease
- ❑ ❑ Abnormal bleeding
- ❑ ❑ Anemia
- ❑ ❑ Blood transfusion Date: _____
- ❑ ❑ Hemophilia
- ❑ ❑ AIDS or HIV infection
- ❑ ❑ Arthritis
- ❑ ❑ Autoimmune disease Type? _____
- ❑ ❑ Rheumatoid arthritis
- ❑ ❑ Systemic lupus erythematosus
- ❑ ❑ Asthma
  Do you use an inhaler?_____
  Date of last attack? _____
- ❑ ❑ Bronchitis
- ❑ ❑ Emphysema
- ❑ ❑ Sinus trouble
- ❑ ❑ Tuberculosis

Yes No
- ❑ ❑ Cancer/ Chemo/ Radiation Treatment
  Type? _____
- ❑ ❑ Chest pain upon exertion
- ❑ ❑ Chronic pain
- ❑ ❑ Diabetes
  ☐ Type I ☐ Type II Last A1C: ____
- ❑ ❑ Eating disorder
- ❑ ❑ Malnutrition
- ❑ ❑ Gastrointestinal disease
- ❑ ❑ G.E. Reflux/ persistent heartburn
- ❑ ❑ Thyroid problems
  ☐ **Hypo**thyroidism (underactive)
  ☐ **Hyper**thyroidism (overactive)
- ❑ ❑ Stroke Date: _____
- ❑ ❑ Glaucoma
- ❑ ❑ Hepatitis, jaundice or liver disease
- ❑ ❑ Neurological disorders
- ❑ ❑ Epilepsy Last seizure: _____

Yes No
- ❑ ❑ Fainting spells or seizures
- ❑ ❑ Mental health disorders: _____
- ❑ ❑ Depression
- ❑ ❑ Anxiety
- ❑ ❑ Sleep disorder
- ❑ ❑ Do you snore? ☐ Diagnosed with sleep apnea
- ❑ ❑ Recurrent infections
- ❑ ❑ Kidney problems
- ❑ ❑ Osteoporosis
- ❑ ❑ Persistent swollen glands in neck
- ❑ ❑ Severe headaches/migraines
- ❑ ❑ Severe or rapid weight loss
- ❑ ❑ Sexually transmitted disease
- ❑ ❑ Excessive urination
- ❑ ❑ Dry Mouth
- ❑ ❑ Ulcers
- ❑ ❑ MRSA

Patient's Signature: _____ Date _____

Signature of Dentist: _____ Date _____

For completion by dentist

Providers Initials: _____

Comments: _____