

Name: _____ date of birth: _____

Please list your family physician and any medical specialists you see at least once a year:

Physician Name	Address	City	Phone#	Name of Specialty
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Medical History Y = yes, N = No

- | | |
|---|---|
| <p>1) Chief Complaint (Why are you seeking dental Care?) _____</p> <p>2) For women only:
 a) Are you pregnant?.....Y...N
 b) Are you nursing?.....Y...N
 c) Are you taking Oral contraceptives?..Y...N</p> <p>3) Do you use any of the following herbal or dietary supplements? Circle all that apply: Echinacea, Garlic, Kava, Valerian, Feverfew, Gingko, St. Johns Wort, Vitamin E</p> | <p>4) Are you wearing contact lenses?.....Y...N</p> <p>5) Have you undergone therapy to reduce high blood calcium (Bisphosphate Therapy)?.....Y...N</p> <p>6) Do you smoke or use smokeless tobacco?.....Y...N</p> <p>7) Do you use controlled substances?(ex.meth,heroin,cocaine)Y...N</p> <p>8) Are you under Weekly care of a Physician.....Y...N</p> <p>9) Do you have any special physical or mental needs?...Y...N</p> <p>10) Have you been hospitalized for any surgical Operation or illness within the last 5 years?.....Y...N
 If yes please explain. _____</p> |
|---|---|

11) Do you have or have you ever had any of the following?

- | | | | |
|----------------------------------|-------------------------------|--|-------------------------|
| Head & Neck Radiation....Y...N | Hemodialysis..... Y...N | Nervous System Disease..... Y...N | Heart Attack.....Y...N |
| Infective Endocarditis.....Y...N | Ventricular Shunt<3mthsY...N | Congestive Heart Failure.....Y...N | Emphysema..... Y...N |
| Mitral Valve Prolapse.....Y...N | Coronary Stent<3mths...Y...N | Thyroid Problems.....Y...N | Glaucoma..... Y...N |
| Congenital Heart Dis.....Y...N | Drug Addiction..... Y...N | Angina (chest pains).....Y...N | Tuberculosis..... Y...N |
| Artificial Heart Valve.....Y...N | Anemia.....Y...N | Irregular Heart Beat.....Y...N | Stroke..... Y...N |
| Implant..... Y...N | Diabetes..... Y...N | Hepatitis A or Hepatitis B.....Y...N | Swollen Ankles.Y...N |
| Joint Replacement.....Y...N | High Blood Pressure.....Y...N | Low Blood Pressure.....Y...N | Heart Murmur....Y...N |
| Cardiac Pacemaker.....Y...N | Rheumatic Fever.....Y...N | Sexually Transmitted Disease.....Y...N | Asthma.....Y...N |
| Organ Transplant<6mths Y...N | Bleeding Problem.....Y...N | Intestinal Disease.....Y...N | Steroid Therapy.Y...N |
| Spleen Removal.....Y...N | Radiation Therapy.....Y...N | Hay Fever Allergies.....Y...N | Kidney Disease.Y...N |
| SLE (Lupus).....Y...N | Cancer.....Y...N | Seizures/Fainting.....Y...N | Ulcers.....Y...N |
| Leukemia.....Y...N | Arthritis.....Y...N | Epilepsy/Convulsions.....Y...N | Heart Disease....Y...N |
| Vascular Graft<6 mths..Y...N | Chronic Infection.....Y...N | AIDS or HIV.....Y...N | Other: (please list) |

12) Are you allergic to any of the following?

- | | | | |
|-----------------------|-------------------------|---------------------------------------|-------------------|
| Penicillin..... Y...N | Barbiturates..... Y...N | Any Metals (eg nickel,etc)..... Y...N | Iodine..... Y...N |
| Sulfa Drug..... Y...N | Aspirin..... Y...N | Local or Dental Anesthetics.....Y...N | Latex..... Y...N |
| Sedatives..... Y...N | Codeine..... Y...N | Other:(please list) | |

Dental History

Names of previous dentist _____ Date of last exam _____

- | | |
|--|--|
| <p>1) Do your gums bleed when brushing or flossing..... Y...N</p> <p>2) Are your teeth sensitive to foods or liquids?..... Y...N</p> <p>3) Do you feel pain in any of your teeth?..... Y...N</p> <p>4) Do you have lumps or sore near your mouth?..... Y...N</p> <p>5) Have you ever had a head, neck, jaw or face injury..... Y...N</p> <p>6) Have you ever experienced th following problems with your jaw? Circle all that apply: Clicking, Pain, Difficulty opening/closing/chewing</p> | <p>7) Do you have frequent headaches?.....Y...N</p> <p>8) Do you clench or grind your teeth?.....Y...N</p> <p>9) Do you bite your cheek frequently?.....Y...N</p> <p>10) Trouble associated with previous dental treatment?.Y...N</p> <p>11) Do you like your smile?.....Y...N</p> <p>12) Circle types of past dental treatment you have experienced:
 Orthodontics, Dentures, Root canal, Implants, Oral Surgery, Periodontal (gum) treatment, TMJ treatment, Fillings</p> |
|--|--|

See Medication list (on reverse side)

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of patient (or parent/guardian) _____ Date _____

medications

Name: _____

Date: _____

Viroqua Dental Center, L.L.C.

Leeanne M. Klum, D.D.S.

Please list any medications.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____