MOUNTAIN VISTA DENTAL
STEVEN W. CARLSON, DDS
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DENTAL HISTORY

Approximate date of last dental exam ______________________

How would you describe your current dental problem? ______________________

	YES	NO
Have you ever had a bad experience in the dental office?	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑
Do your gums bleed when you brush?	❑	❑
Are you aware of any sores, lumps or swelling in your mouth?	❑	❑
Do you feel you have bad breath?	❑	❑
Do you like the appearance of your teeth?	❑	❑
Would you like to have whiter teeth?	❑	❑
Do you have areas where food traps?	❑	❑
Do you have any questions or concerns about your teeth?	❑	❑

If yes, explain ______________________

PATIENT MEDICAL HISTORY

Name of your Primary Care Physician ______________________ Office Phone # ______________________

	YES	NO
Are you in good general health?	❑	❑
Date of last physical: ______________________		
Has there been any major change in you general health in the past year?	❑	❑
Are you under the care of a physician?	❑	❑
If yes, what is/are the condition(s) being treated? ______________________		
Have you had any serious illness, operation, or been hospitalized in the past 5 years ?	❑	❑
If yes, what was the illness or problem? ______________________		
Are you taking or have taken any medicine(s) including non-prescription medication?	❑	❑
Prescribed: ______________________		
Over the counter: ______________________		
Vitamins, minerals, or herbal supplements: ______________________		
Do you take any of the following for osteoporosis/bone loss?	❑	❑
___Actonel ___Boniva ___Reclast ___Zometa ___Aredia ___Fosamax ___Skelid ___Bonefos ___Didronel ___Atelvia		
Are you allergic to any medications?	❑	❑
If yes, list medication and specify the reaction? ______________________		
Are you allergic to any of the following?	❑	❑
___Aspirin ___Local anesthetics ___Food (specify) ________ ___Latex ___Metals		
Do you smoke or use smokeless tobacco (snuff/chew)?	❑	❑
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑
If yes, what was the date of the surgery? ______________________		
If yes, have you had any complications or difficulties with your prosthetic joint?	❑	❑

Has your physician or surgeon recommended that you take antibiotics prior to your dental treatment? Yes No If yes, antibiotic and dose? ______________________

WOMEN ONLY

	YES	NO
Are you pregnant or nursing?	☐	☐
Are you taking birth control pills or hormone replacement?	☐	☐

Please mark an (X) to indicate if you have or have had any of the following:

___Cancer
Type:____________________
Date: ____________________
___Diabetes
Type I (insulin dependent)___
Type II___
___Cardiovascular disease
___Artificial heart valve
___Congenital heart defects
___Heart attack
___High blood pressure
___Low blood pressure
___Congestive heart failure

___Stroke
___Epilepsy
___Frequent headaches/migraines
___Fainting spells or seizures
___Anticoagulant/blood thinner treatment
___Clotting problems
___Acid reflux or persistent heartburn
___Ulcers
___Thyroid problems
___Liver problems
___AIDS/HIV
___Hepatitus___A ___B ___C

___Respiratory problems
___Emphysema
___Bronchitis, etc.
___Asthma
___Shortness of breath
___Sleep disorder
___Sinus trouble

Do you have any disease, or condition, or problem not listed above that you think I should know about?______________
____

I certify that I have read and understand the above. I have reviewed my medical history and confirm that it adequately states past and present conditions.

DATE	PATIENT'S SIGNATURE	STAFF INITIAL