WEBSTER Dental Clinic
St. Croix Regional Medical Center

Adult Medical and Dental History

Patient Name ______________________________ D.O.B. ____________________

Emergency Contact (Name/Phone #) ______________________________

Medical History

1. Physician______________________ Address______________________________

2. When was your last physical examination? ______________________________

3. Are you under the care of a physician? .... □Yes □No
   If yes, for what reason(s)? ______________________________

4. Are you presently taking any medications/drugs/pills/herbals/supplements? .... □Yes □No
   If yes, please list: ______________________________

5. (Women) Is there a chance you are pregnant? .... □Yes □No
   If yes, anticipated due date? ______________________________

6. Do you take oral contraceptives? .... □Yes □No

7. Are you allergic/sensitive to: □None □Codeine □Penicillin □Local Anesthetic □Latex
   □Pine Nuts □Dyes □Other: ______________________________

8. Do you smoke, chew tobacco, or use E-cigarettes? .... □Yes □No
   If yes, please indicate which one(s), daily frequency, and how long? ______________________________

9. Do you have Diabetes? .... □Yes □No
   If yes, please indicate: □Type 1 □Type 2 Last HbA1c date and level: ______________________________

10. Do you have, or have you ever had:

- Abnormal blood pressure.................. □Yes □No
- Anemia .... □Yes □No
- Arthritis .... □Yes □No
- Artificial heart valve/stent/graft....... □Yes □No
- Artificial joint replacements .... □Yes □No
- Asthma .... □Yes □No
- Cancer .... □Yes □No
- Chemical dependency.................. □Yes □No
- Chemotherapy/radiation .... □Yes □No
- Congenital heart defects .... □Yes □No
- Corticosteroid treatment .... □Yes □No
- Epilepsy/seizure .... □Yes □No
- Excessive or prolonged bleeding ..... □Yes □No
- Fainting spells .... □Yes □No
- Glaucoma .... □Yes □No
- Hearing impaired .... □Yes □No
- Heart murmur .... □Yes □No
- Heartpacemaker .... □Yes □No
- Heart surgery .... □Yes □No
- Heart trouble .... □Yes □No
- Hepatitis (Type __) .... □Yes □No
- HIV positive/AIDS .... □Yes □No
- Jaundice .... □Yes □No
- Kidney trouble/Dialysis .... □Yes □No
- Leukemia .... □Yes □No
- Oral herpetic lesions .... □Yes □No
- Osteoporosis/treatmentw/Bisphosphonates □Yes □No
- Psychiatric care.................. □Yes □No
- Rheumatic fever .... □Yes □No
- Sexually transmitted disease .... □Yes □No
- Sinus trouble .... □Yes □No
- Stroke .... □Yes □No
- Thyroid problem .... □Yes □No
- Tuberculosis or Lung Disease .... □Yes □No
- Ulcers/GERD .... □Yes □No

11. Do you take pre-medication for anything? .... ☐Yes ☐No
    If you pre-medicate, what for? ______________________________

12. Have you had any other serious illness, hospitalization or accident? .... ☐Yes ☐No
    If yes, please explain: ______________________________

(Over Please)

Adult Medical and Dental History

Dental History

1. Former Dentist ______________________________________ Address____

2. When did you last visit a dentist? _____________________ When was your last cleaning? _______________________

   X-rays taken? .... □Yes □No

   If yes, □Full Mouth Series □Bitewings □Panoramic

   What was done at your last visit? ____

   Why did you leave that dentist? ____

   Has any dental treatment been recommended to you that you have not had done? _____________________________

3. Are you aware of any dental problems .... □Yes □No

   If yes, please explain: ____

4. Please rate the present condition of your mouth: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***

5. Have you ever been treated for gum disease? .... □Yes □No

   If yes, what was done? ____

6. Do you have well water? .... □Yes □No

7. Is your water fluoridated? .... □Yes □No

8. Are your teeth sensitive to: □Nothing □Sweet □Cold □Heat □Pressure

9. Please rate the appearance of your smile: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***

10. Would you like a whiter smile? .... □Yes □No

11. Would you like straighter teeth?.. □Yes □No

12. Have you had your teeth straightened/worn braces? .... □Yes □No

13. Are you concerned with bad breath (malodor)? .... □Yes □No

14. Are you concerned with snoring or sleep apnea? .... □Yes □No

15. Are you concerned with grinding or clenching your teeth (bruxism)? .... □Yes □No

16. Do you wear a bite guard? .... □Yes □No

17. Are you aware of possible TMJ problems? (Does your jaw joint make noise, lock up, or create pain?) .... □Yes □No

18. Are you interested in sleep/sedation dentistry? .... □Yes □No

19. Is there anything else that would be valuable for your dentist to know to best care for you?

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□ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

□ I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist. □ I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

Patient Signature ____ **Date** ________________________

(Parent/Guardian)

Dentist Signature ____ **Date** ________________________