EASTRIDGE FAMILY DENTAL

Patient Full Name: _____ **Birth Date:** _____

DENTAL HISTORY

Please check the appropriate boxes if you currently have, or have experienced:

□ Tooth sensitivity hot, cold, or sweets
□ Tooth pain when chewing or biting
□ Cracked or Chipped teeth
□ Bleeding gums, How long? _____
□ Pain or soreness in gums
□ Food impaction
□ Unpleasant taste or breath odor
□ Swelling, infection or bumps in mouth
□ Loose teeth
□ Clenching or grinding
□ Jaw joint soreness / pain around the ear area
□ Clicking or popping in the joint when eating
□ Burning tongue
□ Previous orthodontic (braces) treatment
□ Wear a removable dental appliance
□ Mouth breathing or Dry mouth
□ Do you snore?
□ Sleepy throughout the day while working, driving or reading. Persistent tiredness.
□ Have you had a sleep study?
□ Oral habits (nail biting, cheek biting, etc)
□ Dental anxiety
□ Any bad experiences in a dental office?
_____

Dates of Last Dental Exam_____ Gum Disease Screening_____ Oral Cancer Screening_____

What is the primary purpose of today's visit? Any concerns?

_____

_____

How important is your dental health to you, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
How would you rate the appearance of your smile, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
If not a 10, please describe what you would want to improve:

_____

_____

How often do you brush your teeth? _____
Do you use an electric toothbrush? _____
What other dental aids do you use?

□ Floss
□ Mouth rinse, which one _____
□ Water Pik
□ Other_____

Why did you leave your previous dentist? _____
If you could whiten your teeth for a cost anyone could afford, would you do it? _____

What treatments are you interested in learning about?

□ Orthodontics (braces) or Clear Braces
□ Implants (replacing missing teeth)
□ Dentures or Partial Dentures
□ Sedation (anxiety-free sleep dentistry)
□ Gum Disease Treatments
□ Cosmetic Dentistry or Veneers
□ Teeth Whitening
□ Sleep Apnea treatments
□ Denture Stabilization
□ Headaches or Head/Neck/Jaw Pain

PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU.

Skyview Family Dental
5314 S. Yale Ave, Suite 1100, Tulsa, OK 74135
918-492-3003

MEDICAL HISTORY

Are you being treated by a physician now? _____ Known conditions _____
Date of last Physical Exam?_____ Physician _____
Address_____ Phone _____
City, ST, zip code _____
My Pharmacy of Choice: _____ Phone _____
Have you been hospitalized in the last 5 years? Reason?_____

IN THE FOLLOWING SECTIONS, PLEASE CHECK ALL THAT APPLY.

DO YOU HAVE OR HAVE YOU HAD A HISTORY OF:

- ☐ Chest pain (angina)
- ☐ Swollen ankles
- ☐ Recent weight loss, fever, night sweats
- ☐ Persistent cough, coughing up blood
- ☐ Bleeding, bruising easily
- ☐ Sinus problems
- ☐ Difficulty swallowing
- ☐ Diarrhea, constipation, blood in stools
- ☐ Frequent vomiting or nausea
- ☐ Difficulty urinating, blood in urine
- ☐ Frequent Dizziness
- ☐ Ringing or Pain in ears
- ☐ Frequent Headaches
- ☐ Blurred vision
- ☐ Seizures
- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Dry mouth
- ☐ Jaundice
- ☐ Joint pain, stiffness, arthritis
- ☐ Heart disease or attack
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Heart Valve problems
- ☐ Stroke, Stent or hardening of arteries
- ☐ Prosthetic Heart Valve
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Asthma
- ☐ Emphysema, COPD, Lung disorders
- ☐ Tuberculosis
- ☐ Kidney, Bladder or Liver Disease
- ☐ Hepatitis A, B, or C
- ☐ Stomach problems, ulcers, colitis
- ☐ Thyroid or Adrenal Disease
- ☐ Depression, or Anxiety Disorders
- ☐ Autism, Schizophrenia, psychiatric care
- ☐ Tumors or Cancer
- ☐ Radiation or Chemotherapy treatments
- ☐ Alzheimer's or Dementia
- ☐ Parkinson's or Neuromuscular Diseases
- ☐ HIV Positive
- ☐ AIDS
- ☐ Eye diseases or glaucoma
- ☐ Sleep Apnea
- ☐ Skin diseases
- ☐ Anemia
- ☐ Venereal Disease
- ☐ Canker Sores or Cold Sore/Fever Blister
- ☐ Hospitalization
- ☐ Blood transfusions
- ☐ Antibiotic pre-med prior to dental care
- ☐ Artificial Joint or replacement

SURGERIES: _____
ALLERGIES to medications, latex, food_____

ARE YOU TAKING ANY OF THE FOLLOWING? CHECK ALL THAT APPLY.

Yes	No	Tobacco in any form	Yes	No	Antacids
Yes	No	Alcohol	Yes	No	Consume grapefruit or grapefruit extract
Yes	No	Recreational Drugs			
Yes	No	Bisphosphonates (for Osteoporosis / Bone) such as: Fosamax, Boniva, Actonel, Zometa, or Aredia?			

Please List All Current Medications (prescription, and over-the-counter) and all Supplements

_____

_____

WOMEN ONLY:

Yes	No	Are you pregnant or nursing	Yes	No	Taking birth control/hormone pills
Yes	No	Have you had a hysterectomy	Yes	No	Taking fertility drugs

ALL PATIENTS:
Do you have or have you had any other diseases
or medical problems NOT listed on this form? Yes No

If so, please explain_____

To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of any changes in my health and/or medication.

PATIENT SIGNATURE:_____DATE:_____