Dental Designer
Dr. Harmanpreet Kaur

Patient's Name: ______________________

Date Completed: __________

Medical/Dental History

Blood
- Blood Disorders or Anemia ☐ Yes ☐ No
- Bruises easily ☐ Yes ☐ No
- Excessive bleeding following a scratch, cut, or tooth extraction ☐ Yes ☐ No

Bones, Muscles, Joints
- Arthritis ☐ Yes ☐ No
- Frequent fractures or dislocations ☐ Yes ☐ No
- Knee, Hip, or Shoulder replacement ☐ Yes ☐ No
- Other joint or muscle problems ☐ Yes ☐ No
- Muscular Dystrophy ☐ Yes ☐ No
- Multiple Sclerosis ☐ Yes ☐ No

Cardiovascular System
- High or Low Blood Pressure ☐ Yes ☐ No
- Heart Trouble; Coronary artery disease, heart attack, heart defects ☐ Yes ☐ No
- Frequent Chest Pain (angina) or shortness of breath ☐ Yes ☐ No
- Heart Infection (endocarditis, pericarditis) ☐ Yes ☐ No
- Heart valve disease, repaired, or replaced ☐ Yes ☐ No
- Swollen Ankles or heart failure ☐ Yes ☐ No
- Irregular heart beat or rhythm ☐ Yes ☐ No
- Stroke or Mini Stroke ☐ Yes ☐ No
- Pacemaker or defibrillator ☐ Yes ☐ No

Endocrine
- Thyroid, adrenal or other gland problems ☐ Yes ☐ No
- Cortisone or hormone treatment ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Member of family with Diabetes ☐ Yes ☐ No

Kidney
- Kidney Disease ☐ Yes ☐ No
- Frequent Urination ☐ Yes ☐ No

Gastrointestinal System
- Stomach or intestinal trouble ☐ Yes ☐ No
- Liver trouble, gall bladder trouble or stones ☐ Yes ☐ No
- Eating Disorders ☐ Yes ☐ No

Infectious Diseases
- Gonorrhea, Syphilis, Herpes ☐ Yes ☐ No
- Tuberculosis (self or family) ☐ Yes ☐ No
- Hepatitis or Jaundice ☐ Yes ☐ No
- Have you ever been diagnosed with HIV/AIDS ☐ Yes ☐ No

Nervous System
- Nervous, Mental Disorder, Anxiety ☐ Yes ☐ No
- Epilepsy, seizures, convulsions or fainting ☐ Yes ☐ No
- Neuritis, neuralgia or numbness ☐ Yes ☐ No
- Psychiatric Illness ☐ Yes ☐ No
- Dental fear/ phobia ☐ Yes ☐ No
- Mental retardation ☐ Yes ☐ No
- Traumatic brain injury ☐ Yes ☐ No
- Alzheimer's disease/ Dementia ☐ Yes ☐ No
- Downs Syndrome ☐ Yes ☐ No
- Cerebral Palsy ☐ Yes ☐ No
- Autism, Asperger's or Pervasive Development Disorder ☐ Yes ☐ No

Other
- Tumors, growths, cysts, or cancer ☐ Yes ☐ No

IF THE QUESTIONS HIGHLIGHTED BELOW ARE YES, PLEASE EXPLAIN

- Radiation Therapy ☐ Yes ☐ No
- Recent gain or loss of weight ☐ Yes ☐ No
- Operations, Hospitalizations ☐ Yes ☐ No

If yes, please explain: ______________________

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- Skin Disorders ☐ Yes ☐ No
- Any other Disease or illness not mentioned ☐ Yes ☐ No

If yes, please explain: ______________________

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- Pregnant ☐ Yes ☐ No
- Breast feeding ☐ Yes ☐ No
- Tobacco use ☐ Yes ☐ No
- Drug Use ☐ Yes ☐ No
- Alcohol Use ☐ Yes ☐ No
- Received any transfusions ☐ Yes ☐ No
- Complications with surgery or anesthesia ☐ Yes ☐ No

Respiratory Systems
- Respiratory/ Lung Disease ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Sleep Apnea ☐ Yes ☐ No

Bisphosphonates
- Received or are you taking any medications known as Bisphosphonates (Zometa, Aredia, Fosamax) ☐ Yes ☐ No
- Received or currently receiving Chemotherapy for treatment of any cancer? ☐ Yes ☐ No
- Are you taking any drugs for Osteoporosis? ☐ Yes ☐ No

If yes, please explain: ______________________

Allergies or Reaction to:
- Penicillin ☐ Yes ☐ No
- Sulfa ☐ Yes ☐ No
- Other Antibiotics ☐ Yes ☐ No
- Aspirin, Ibuprofen or any other medications for pain ☐ Yes ☐ No

If yes, please explain: ______________________

- Local anesthetics ☐ Yes ☐ No
- Food allergies ☐ Yes ☐ No
- Latex allergy ☐ Yes ☐ No
- Other Allergies ☐ Yes ☐ No

If yes, explain: ______________________

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Medications
- Birth Control ☐ Yes ☐ No

If yes, please explain: ______________________

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- Over the counter medications ☐ Yes ☐ No

If yes, please explain: ______________________

- Vitamins, herbals, other supplements ☐ Yes ☐ No

If yes, please explain: ______________________

- Other medications ☐ Yes ☐ No

If yes, please explain: ______________________

Past Dental History

How long since your last dental visit? ______________

Was all necessary work completed? ☐ Yes ☐ No

If not, explain: ______________

Have you made regular visits? ☐ Yes ☐ No

If not, explain: ______________

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you have soreness in the muscles of your face or around the ear? ☐ Yes ☐ No

Does your jaw click or pop? ☐ Yes ☐ No

Do your gums bleed or hurt when you brush? ☐ Yes ☐ No

Have you ever had periodontal surgery (Gum Surgery)? ☐ Yes ☐ No

General anesthesia for Dental Care? ☐ Yes ☐ No

Any major injuries to the face or teeth? ☐ Yes ☐ No

What are your current dental habits? ______________

Do you floss? ☐ Yes ☐ No

Do you rinse? ☐ Yes ☐ No

Do you use any other dental aids? ☐ Yes ☐ No

Are you happy with your teeth? ☐ Yes ☐ No

If not, explain: ______________

Have you had teeth removed? ☐ Yes ☐ No

If not, explain: ______________

Were they replaced? ☐ Yes ☐ No

If not, explain: ______________

Are any teeth sensitive to:

Hot ☐ Yes ☐ No

Sweets ☐ Yes ☐ No

Cold ☐ Yes ☐ No

Chewing ☐ Yes ☐ No

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Vital Signs

Height (in inches) ______________

Weight (in lbs.) ______________

Blood Pressure

Systolic ______________

Diastolic ______________

Pulse ______________

Temperature ______________

ASA Classification

ASA1 ☐ Yes ☐ No

ASA2 ☐ Yes ☐ No

ASA3 ☐ Yes ☐ No

ASA4 ☐ Yes ☐ No