Summit FAMILY DENTISTRY
The Peak of Dental Care

9271 Peach Street
Waterford, PA 16441
(814) 923-4510 (office)
(814) 923-4199 (fax)
sfd@SummitFamilyDentistry.net

Medical History

PATIENT NAME:_____ BIRTHDAY:_____

Although dental personal primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you currently under a physician's care? ☐ Yes ☐ No If yes, please explain:_____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please explain:_____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please explain:_____

Do you use tobacco? ☐ Yes ☐ No If yes, what kind and how long:_____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain:_____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain:_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ☐ Yes ☐ No

Women: Are you
☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Current Height _____ Weight _____lbs.

Are you allergic to any of the following?
☐ **None known** ☐ Penicillin ☐ Codeine ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs
☐ Sulfite ☐ Aspirin ☐ PABA ☐ Other - If so, please explain: _____

Do you have, or have you had any of the following?

- ☐ Acid Reflux/GERD
- ☐ AID/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia-Type:_____
- ☐ Angina
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ COPD
- ☐ Cortisone Medicine
- ☐ Current UTI
- ☐ Diabetes-Type:_____
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Endocarditis
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting spells/Dizziness
- ☐ Fibromyalgia
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker/ICD
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss/Gain
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Use of CPAP Machine

Please Continue on Reverse Side

Have you ever had any serious illness not listed on the previous page? ⬭ Yes ⬭ No If yes, please explain:

_____

Name, Phone Number and Location of your PCP: _____

Name, Phone Number and Location of your previous Dentist: _____

What is the most important thing to you about your dental visit today? _____

_____

What would you like to change about your smile?

☐Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Missing Teeth ☐ Whiter Teeth ☐ Smile Makeover

Please mark any that may apply to you

Pain/Discomfort	**Function**	**Habits**	**Periodontal (Gum) Health**
☐ Sensitivity to hot	☐ Grinding/Clenching	☐ Thumb sucking	☐ Bleeding Gums
☐ Sensitivity to cold	☐ TMD	☐ Nail-biting	☐ Swollen Gums
☐ Sensitivity to sweet	☐ Mouth Breathing	☐ Cheek/Lip biting	☐ Bad Breath
☐ Broken teeth/fillings	☐ Sore Muscles (neck, shoulders)	☐ Chewing on ice/foreign objects	☐ Loose tipped, shifting teeth
☐ Worn/flat teeth	☐ Difficulty Opening		☐ Previous perio/gum disease
☐ Dry Mouth	☐ Difficulty Chewing		

How often do you brush? _____

How often do you floss?_____

Do you use mouth washes or rinses? ☐ Yes ☐ No

For Doctors Use:

Type: Electric Manual

ES S M H

Type: S T P TP

Have you ever had any adverse effects from dental treatment or dental anesthesia? ☐ Yes ☐ No

If Yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF DOCTOR _____DATE_____

ASA CLASSIFICATION: I II III IV V