TANEGADENTAL

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Medical and Dental Health History

Name of Medical Doctor: _____ City: _____ Phone: ( )_____

Date of last medical Exam: _____ *(Women only)* Is there any possibility you are pregnant? No ☐ Yes ☐ ____Months

Have you even had or do you have any of the following? Please check below.

☐ Heart murmur
☐ Rheumatic fever
☐ Mitral Valve Prolapse
☐ Prosthetic joints / Heart Valves
☐ Pacemaker
☐ Heart problems: _____
☐ High Blood Pressure
☐ Stroke, when: _____
☐ Blood trouble, anemia, leukemia
☐ Excessive bleeding
☐ Hepatitis: A or B or C or other
☐ Diabetes: Type I or Type II

☐ Tired jaw muscles
☐ Dizziness/Loss of Balance
☐ Earaches
☐ Ringing in ears
☐ Ear stuffiness
☐ Jaw pain
☐ Neck pain
☐ Headaches/Facial Pain
☐ Clenching/Grinding
☐ Change in bite
☐ Jaw locking/catching
☐ Jaw clicking/popping

☐ Lung trouble (TB, asthma, emphysema)
☐ Kidney disease: _____
☐ Arthritis, Degenerative joint disease
☐ Fainting spells, epilepsy, convulsions
☐ Nervous breakdown/ anxiety disorders
☐ Indium, cobalt or Lithium treatment
☐ Radiation or chemotherapy
☐ Tumor or cancer
☐ Shortness of Breath
☐ Venereal disease
☐ AIDS related complex
☐ Other: _____

Are you now taking medicines for: (please specify medication)

☐ Pain _____
☐ Headaches _____
☐ Arthritis _____
☐ Allergy (asthma) _____
☐ Stomach (ulcers) _____
☐ Thyroid _____
☐ Other _____

☐ Heart _____
☐ Nerves _____
☐ Sleeping _____
☐ Blood (thinners) _____
☐ GERD _____
☐ Birth Control _____

Have you ever been allergic to, been sick from, or been told not to take:

☐ Latex: _____
☐ Metals: _____
☐ Antibiotics (Penicillin, other): _____
☐ Narcotics (Codeine, other): _____
☐ Aspirin, NSAIDS: _____
☐ Anesthetics (Novocaine, other): _____
☐ Other medications: _____

Do you have any disease conditions, or problems that are not mentioned above?
Do you smoke? No ☐ Yes ☐ **If yes, how many cigarettes a day? How many years?**
Have you ever taken the diet drug combination, Fen-Phen? No ☐ Yes ☐ other **diet drugs?**

Previous Dentist's Name:_____ City:_____

Reason for leaving previous dentist:_____

Have you ever had or do you have any of the following?

☐ Orthodontic treatment _____
☐ Dental extractions _____
☐ Periodontal treatment _____
☐ Gum surgery _____
☐ Dental implants _____
☐ Gum disease _____
☐ Endodontics/Root canals _____
☐ Mouth guards/Sports guards _____
☐ Night guards _____
☐ Teeth whitening _____
☐ Sleep dentistry/general anesthesia/laughing gas
☐ Fear or anxiety related to dental treatment

What is the reason you are seeking dental care now?

☐ General Check up
☐ TMJ
☐ Orthodontics/Invisalign
☐ Whitening
☐ Improve your smile/teeth
☐ Reconstruction of the mouth
☐ Tooth pain
☐ Other: _____

Do your gums bleed when you brush or floss? ☐ Yes ☐ No
How would you rate your previous experiences at the dentist?
☐ Excellent ☐ Good ☐ Average ☐ Painful/frightening

What has prevented you from getting quality dental care in the past?
☐ Money ☐ Pain/fear ☐ No interest/need ☐ Not applicable
Other: _____

I, the undersigned, have given the above information, have reviewed it and find it accurate. If there are any later changes, I will so inform the practice.

Patient Signature: _____ Date: _____

Patient Name (please print): _____