Glenn Family Dentistry

glennfamilydentistry.com
contact@glennfamilydentistry.com
3600 S. Beeler Street, Ste 120 • Denver, CO 80237
(303)779-2592

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

We value your health and your privacy. As always in our practice, your health information is protected and will be kept confidential. All information included in this form is only asked in order that we may treat you safely and with the utmost of care.

Medical History

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

- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Cancer treatment
- ☐ Coronary Stint Placed
- ☐ Epilepsy or Seizures
- ☐ Glaucoma
- ☐ Headaches/Migraines
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Malnutrition/Eating Disorder
- ☐ Multiple Sclerosis
- ☐ Pre-Med Needed
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Systemic lupus
- ☐ Tumors
- ☐ Alzheimer's Disease
- ☐ Arthritis/Gout
- ☐ Autoimmune disease
- ☐ Chronic Pain
- ☐ Diabetes I or II
- ☐ Fainting spells
- ☐ Growths
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hypoglycemia
- ☐ Leukemia
- ☐ Mental Disorders/Psychiatric Care
- ☐ Neurologic Disorders
- ☐ Pregnancy
- ☐ Rapid weight loss
- ☐ Rheumatism
- ☐ Sleep disorder
- ☐ Tattoos/Body Piercing
- ☐ Ulcers
- ☐ Anemia
- ☐ Artific. Heart Valve
- ☐ Bleeding disorder/Bruise Easily/Excessive Bleeding
- ☐ Cochlear implants
- ☐ Dizziness
- ☐ Frequent Cough
- ☐ HIV or AIDS
- ☐ Heart Defect/ Congenital Heart Disorder
- ☐ Heart Surgery
- ☐ Irregular Heart Beat
- ☐ Liver Disease
- ☐ Methemoglobinemia
- ☐ Osteoporosis
- ☐ Prev. endocarditis
- ☐ Recurrent Infections
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid/Parathyroid problems
- ☐ Unexplained Fever
- ☐ Angina/Chest Pain
- ☐ Artificial Joints
- ☐ Blood disease/Hemophilia
- ☐ Cold Sores/Fever Blisters/Oral Herpes
- ☐ Emphysema
- ☐ GI disorders
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Hepatitis A, B, or C
- ☐ Jaundice
- ☐ Low blood pressure
- ☐ Mitro Valve Prolapse
- ☐ Pacemaker
- ☐ Pulmonary Shunt
- ☐ Respiratory Problems/Lung Disease
- ☐ Sickle Cell Disease
- ☐ Swelling Limbs
- ☐ Tuberculosis
- ☐ Venereal disease/ STD

If you checked any boxes above, please provide us with dates and details so we may ensure your health and safety:

_____

_____

_____

Do you have any disease, condition, or problem not listed ? If yes, please describe:

_____

_____

Name of Practice/Primary Care Physician and phone number:

_____

_____

Have you ever had an allergic reaction to

- ☐ aspirin
- ☐ NSIADS
- ☐ sulfa
- ☐ clindamycin
- ☐ tree nuts
- ☐ shell fish
- ☐ soy
- ☐ latex
- ☐ other
- ☐ ibuprofen
- ☐ codeine
- ☐ tetracycline
- ☐ doxycycline
- ☐ peanuts
- ☐ iodine
- ☐ local anesthetic
- ☐ acrylic
- ☐ acetaminophen
- ☐ penicillin/amoxicillin
- ☐ erythromycin
- ☐ gluten
- ☐ fish
- ☐ milk/dairy
- ☐ fluoride
- ☐ metals (including nickel, gold, silver)

If you checked yes to other allergies, please list in the space provided:

_____

_____

Have you changed your eating habits or are you on a special diet?

_____

_____

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? ◯ Yes ◯ No

If yes, please name the physician or dentist making the recommendation and which type of medication has been recommended.

_____

_____

Have you had an orthopedic total joint (hip, knee, etc) replacement? ◯ Yes ◯ No

If yes, please provide the date of surgery, surgeon's name and note if any complications

_____

_____

Have you been hospitalized or had any surgeries other than above? (please provide description, surgeon if known, date, and if any complications)

_____

_____

Do you have any surgeries scheduled? ◯ Yes ◯ No

If yes, please provide description, surgeon's name, and date of upcoming surgery.

_____

_____

Have you had any injuries that involved your head or neck?

_____

_____

Please list any medications your are taking including prescription, herbals, oils, or vitamins: (include dosage, how often, times of day taken and what medication is treating)

_____

_____

_____

_____

Are you taking, or scheduled to begin taking, Alendronate (Fosamax) or Residronate (Actonel) for Osteoporosis or Paget's disease?

◯ Yes ◯ No

If yes, in IV form or oral form?

◯ IV ◯ Oral

Since 2001, have you been treated or are you presently scheduled to begin treatment with intravenous (IV) bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications?

◯ Yes ◯ No

If yes, please provide dates of treatment

_____

_____

Females only: Are you currently pregnant? ◯ Yes ◯ No

Females only: Are you currently nursing? ◯ Yes ◯ No

Dental History

Name of previous dentist? _____

Have your past dental experiences been positive? ◯ Yes ◯ No

If no, please describe.

_____

_____

Do you have dental exams on a routine basis? ◯ Yes ◯ No

Please give the date of your last dental exam (to the best of your knowlege). _____

Do you know what year your last full mouth set of xrays were taken? _____

Do you have a specific dental problem today?

_____

_____

Would you like to change anything about your smile?

_____

_____

Do you or anyone in your family struggle with cavities? ◯ Yes ◯ No

Do you or anyone in your family have periodontal disease? ◯ Yes ◯ No

Have you had Periodontal treatment/surgery? ◯ Yes ◯ No

If yes, please provide type of treatment, date of treatment and name of Periodontist

_____

_____

How many times per day do you brush your teeth? _____

Does food catch between your teeth? ◯ Yes ◯ No

If yes, where? _____

How often do you clean in-between your teeth?

◯ I don't floss/ use picks or other devices ◯ A few times a year ◯ Once a month

◯ 1-2 times a week ◯ Once per day ◯ Twice per day

What tools do you use to clean your teeth? (check all that apply)

☐ Manual toothbrush ☐ Electric toothbrush ☐ String floss: Waxed, Glide, Other ☐ Floss picks

☐ Interproximal brushes ☐ Interproximal picks ☐ Waterpik ☐ Air flosser

☐ Other

Notes/Comments:

_____

_____

Do your gums ever bleed? ◯ Yes ◯ No

If your gums bleed, when and how often?

_____

_____

Have you ever had Orthodontic treatment? ◯ Yes ◯ No

If yes, please provide type of treatment, date of treatment and name of Orthodontist

_____

_____

Have you had wisdom teeth extracted? ◯ Yes ◯ No

If yes, please provide date of extractions and name of Oral Surgeon

_____

_____

Do you wear or has it been recommended to wear a removable appliance? (check all that apply)

☐ Orhtodontic retainer ☐ Night guard ☐ Snore appliance ☐ Partial denture ☐ Full denture

Do you clench or grind your teeth during the day? ◯ Yes ◯ No

Have you been made aware of clenching or grinding your teeth during sleep? ◯ Yes ◯ No

Do you have chronic headaches, neck, or shoulder pain? ◯ Yes ◯ No

Are your teeth or jaws tired when you awaken? ◯ Yes ◯ No

Have you ever had pain in your jaw joints, sides of your face, or ears? ◯ Yes ◯ No

Have your jaws ever clicked or popped when you open your mouth? ◯ Yes ◯ No

Has your jaw ever locked open or closed? ◯ Yes ◯ No

Have you ever experienced difficulty moving your jaw or opening your mouth wide? ◯ Yes ◯ No

Do you chew on only one side of your mouth? ◯ Yes ◯ No

How often do you wake in the morning with headaches or jaw pain/discomfort?
◯ Never ◯ Rarely ◯ Every day ◯ Weekly ◯ Monthly

Has anyone ever told you that you snore? ◯ Yes ◯ No

Have you ever had a sleep study or wanted to? Why?

_____

_____

If you have been diagnosed with Sleep Apnea, do you wear:
◯ CPAP ◯ BIPAP ◯ Oral Appliance ◯ Other

Have you ever smoked cigarettes or marijuana? ◯ Yes ◯ No

If yes, do you still currently smoke or vape? ◯ Yes ◯ No

If yes, how often?
☐ 1x or less/ week ☐ 2-7x/ week ☐ 1-4x/day ☐ more than 5x/day

Have you ever had an alcoholic beverage? ◯ Yes ◯ No

How many glasses of beer or wine do you consume per week?

◯ 1 or less ◯ less than 5 ◯ less than 10 ◯ more than 10

How many shots of spirits per week?
◯ Less than 1 ◯ Less than 5 ◯ Less than 10 ◯ More than 10

Do you ever combine alcohol with smoking? ◯ Yes ◯ No

Have you ever had any sores in your mouth? ◯ Yes ◯ No

If yes, please describe.

_____

_____

Are you being treated or have been treated for drug addiction/alcoholism? ◯ Yes ◯ No

If yes, please describe.

_____

_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

◯ Yes ◯ No

Signature _____ **Date** _____

To be completed by your practitioner

Reviewed by Dr.

◯ Megan Harbaugh, D.D.S. ◯ Amber Gotch, RDH ◯ Amy Fink, RDH ◯ Visiting Practitioner

Today's BP _____

Today's Pulse _____

Any other significant findings?

Signature _____ **Date** _____

Response Date: _____