Great Lakes
— PROSTHODONTICS

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Anthony Deliberato, DDS · Christian Loo, DDS · Eric Guirguis, DDS, MSD

Medical & Dental History

Type into the shaded boxes and tick the boxes that apply, then save the file.
Your answers are used only to treat you safely. Tell us of any change at future visits.

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

PHYSICIAN

PHYSICIAN NAME | PRACTICE | PHONE

DATE OF LAST PHYSICAL EXAMINATION | REASON FOR THAT VISIT

CURRENT HEALTH

Are you in good health? ☐ Yes ☐ No

Has your health changed in the last year? ☐ Yes ☐ No

Are you under the care of a physician now? ☐ Yes ☐ No

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN

Have you been hospitalised or had a serious illness in the last five years? ☐ Yes ☐ No

IF YES, DESCRIBE AND GIVE APPROXIMATE DATES

MEDICAL CONDITIONS — PLEASE TICK ANYTHING YOU HAVE HAD

☐ Heart disease	☐ Heart attack	☐ Heart murmur
☐ Artificial heart valve	☐ Pacemaker or defibrillator	☐ High blood pressure
☐ Low blood pressure	☐ Angina	☐ Stroke
☐ Mitral valve prolapse	☐ Rheumatic fever	☐ Congenital heart defect
☐ Asthma	☐ Emphysema or COPD	☐ Tuberculosis
☐ Sleep apnoea	☐ Sinus trouble	☐ Shortness of breath
☐ Diabetes — Type 1	☐ Diabetes — Type 2	☐ Thyroid disorder
☐ Kidney disease	☐ Liver disease	☐ Hepatitis A / B / C
☐ Anaemia	☐ Blood transfusion	☐ Bleeding or clotting disorder
☐ Cancer	☐ Chemotherapy	☐ Radiation therapy
☐ Artificial joint or implant	☐ Osteoporosis	☐ Arthritis
☐ Epilepsy or seizures	☐ Fainting spells	☐ Neurological disorder
☐ Depression or anxiety	☐ Eating disorder	☐ HIV or AIDS
☐ Autoimmune disease	☐ Glaucoma	☐ Stomach or intestinal disease

Any other condition not listed? ☐ Yes ☐ No

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IF YES, PLEASE DESCRIBE

MEDICATIONS, ALLERGIES AND BISPHOSPHONATES

LIST ALL MEDICATIONS, VITAMINS AND SUPPLEMENTS YOU TAKE, WITH DOSAGE

Allergic or sensitive to: ☐ Penicillin ☐ Other antibiotics ☐ Aspirin ☐ Codeine ☐ Local anaesthetic ☐ Latex ☐ Metals ☐ Sulfa drugs ☐ Iodine ☐ Acrylic ☐ No known allergies

OTHER ALLERGIES, AND WHAT REACTION YOU HAD

Important — bone medications. Please tell us if you have ever taken a bisphosphonate or bone-density medication, by tablet or by infusion. These include Fosamax, Actonel, Boniva, Reclast, Zometa, Aredia, Prolia and Xgeva. These medicines affect how the jaw heals and directly change how we plan implant and surgical treatment.

Have you ever taken any of these medications? ☐ Yes ☐ No ☐ Not sure

WHICH MEDICATION | WHEN TAKEN (FROM / TO) | STILL TAKING?

FOR WOMEN

☐ Pregnant ☐ Trying to become pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ None of these

IF PREGNANT, DUE DATE | WEEKS

TOBACCO, ALCOHOL AND OTHER SUBSTANCES

Do you use tobacco or vape? ☐ Never ☐ Currently ☐ Formerly

TYPE AND AMOUNT PER DAY | IF FORMER, YEAR YOU STOPPED

Alcohol use: ☐ None ☐ Occasional ☐ Weekly ☐ Daily

Do you use recreational drugs? ☐ Yes ☐ No

DENTAL HISTORY

DATE OF YOUR LAST DENTAL VISIT | DATE OF LAST FULL-MOUTH X-RAYS | LAST CLEANING

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Reason for today's visit: ☐ Consultation ☐ Second opinion ☐ Referred for treatment ☐ Emergency or pain
☐ Failing existing work ☐ Implants ☐ Dentures or partials ☐ Crowns or bridges

IN YOUR OWN WORDS, WHAT WOULD YOU MOST LIKE US TO ADDRESS?

CURRENT DENTAL CONCERNS — PLEASE TICK ANY THAT APPLY

- ☐ Pain or sensitivity
- ☐ Missing teeth
- ☐ Grinding or clenching
- ☐ Denture does not fit
- ☐ Bad breath or taste
- ☐ Unhappy with appearance
- ☐ Bleeding gums
- ☐ Broken or chipped teeth
- ☐ Jaw joint pain or clicking
- ☐ Denture is loose
- ☐ Dry mouth
- ☐ Teeth have shifted
- ☐ Loose teeth
- ☐ Worn-down teeth
- ☐ Headaches on waking
- ☐ Difficulty chewing
- ☐ Food catching between teeth
- ☐ Sores in the mouth

Have you had orthodontic treatment? ☐ Yes ☐ No

Have you had periodontal (gum) treatment? ☐ Yes ☐ No

Have you had oral surgery or extractions? ☐ Yes ☐ No

Have you had dental implants placed? ☐ Yes ☐ No

PLEASE GIVE DETAILS OF ANY OF THE ABOVE, WITH APPROXIMATE DATES

Have you ever had a difficult or upsetting dental experience? ☐ Yes ☐ No

How would you describe your comfort at the dentist? ☐ Comfortable ☐ A little anxious ☐ Very anxious

SIGNATURE

To the best of my knowledge, the information on this form is complete and correct. I understand that giving inaccurate or incomplete information may be dangerous to my health, and that it is my responsibility to inform this practice of any change in my medical status or medications.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

PRINT NAME

RELATIONSHIP IF SIGNING FOR THE PATIENT

FOR OFFICE USE — REVIEWED BY / NOTES