

Pound and Pound Family Dentistry, PLLC
MEDICAL HISTORY

Patient Name _____ D.O.B. _____

Emergency Contact (Name/Phone#) _____

Physician _____ Physician Phone # _____

When was your last physical examination? _____

Are you currently under the care of a physician?.....*Yes *No

If yes, for what reason(s)? _____

(Women) Is there a chance you are pregnant? _____ If yes, anticipated due date? _____

(Women) Do you take oral contraceptives?.....*Yes *No

Do you smoke, chew tobacco, or use E-cigarettes?.....*Yes *No

If yes, please indicate which one(s), daily frequency, and how long? _____

DO YOU HAVE, OR HAVE YOU EVER HAD (PLEASE CIRCLE):

- | | | |
|-------------------------------------|---|---|
| Anemia | GERD/Acid Reflux/Ulcers/Colitis | Kidney Disease/Dialysis |
| Anxiety/Depression | Hearing Loss/Hearing Aids | Osteoporosis (treated with
Bisphosphonate Drugs) |
| Arthritis | Hepatitis | Pacemaker/Defibrillator |
| Artificial Joints/Bones | HIV+/AIDS | Seasonal Allergies/Hay Fever |
| Blood Thinners | High/Low Blood Pressure | Sexually Transmitted Disease |
| Cancer | High Cholesterol | Shingles |
| Cardiac AFIB | Heart Bypass/Stents/Other Heart Surgery
or Procedure | Sinus Trouble |
| Chemotherapy/Radiation | Heart Attack | Stroke/TIA |
| Diabetes | Heart Defect/Murmur | Thyroid (Low/High) |
| Dementia/Alzheimer's | Heart Valve Replacement | Tuberculosis |
| Drug/Alcohol (Dependency/Treatment) | Headaches/Migraines | Walker/Wheelchair |
| Epilepsy/Seizures/Fainting | Hemophilia/Bleeding | |
| Vision Problems/Glaucoma | | |

Please list any other illness, hospitalization, or surgery not listed above:

Are you required by your physician or surgeon to pre-medicate for dental appointments?.....*Yes *No

If yes, please give reason here: _____

ALLERGIES: Are you allergic to LATEX? Penicillin? Local Anesthetic? Others? Please list:

Are you presently taking any medications or supplements?.....*Yes *No If yes, please list. Include over the counter. If you have a longer list with you, we will be happy to copy and scan it. _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical issues.

Signature _____ Date _____

Welcome to Pound and Pound Family Dentistry, PLLC
NEW PATIENT DENTAL HISTORY

Patient Name _____ Today's Date _____

Previous Dentist _____ Last Visit Date _____

When was your last cleaning? _____ Were Xrays taken? _____

Why have you come to the dentist today? _____

Has any treatment been recommended to you that you have not had done? _____

Are you currently having pain?.....*Yes *No If yes, please describe: _____

Are your teeth sensitive to (please circle): Nothing Sweet Chewing Cold Heat Pressure

Are you concerned with grinding or clenching your teeth (bruxism)?.....*Yes *No

Do you currently or have you ever worn a bite splint?.....*Yes *No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ)?.....*Yes *No

Do you have any issues with the use of dental anesthetics (i.e. use of Lidocaine, Septocaine with Epinephrine)?.....*Yes *No

Have you ever experience Bell's Palsy from local anesthetic?.....*Yes *No

Have you ever had your teeth straightened/Worn braces?.....*Yes *No

Would you like straighter teeth?.....*Yes *No

Have you ever been treated for gum disease?.....*Yes *No If yes, what did you have done? _____

How many times a day do you brush? _____ How many times a week do you floss? _____

Do your oral tissues (gums) bleed when you brush and/or floss?.....*Yes *No

Your current dental health is (please circle): Good Fair Poor

Please rate the appearance of your smile: *Poor* 1 2 3 4 5 6 7 8 9 10 *Excellent*

Would you like a whiter smile?.....*Yes *No

How did you hear about us? _____

Do you have other family members that are patients here? _____