McKinley Family Dental

13432 McKinley Hwy Mishawaka, IN 46545

Patient name:____________________________________ **Date of Birth**:____________________________

1. Yes/ No Are you in good general health?
   a. If NO please explain:____
   ____
   ____
2. Yes/No Has there been a change in your health in the past year?
   a. If YES Please explain:____
   ____
3. Yes/No Have you had a serious illness in the past three years?
   a. If YES please explain:____
   ____
4. Yes/No Are you being treated by a physician now?
   a. If YES please explain:
   ____
   ____
5. Yes/No Have you had problems with prior dental treatment?
   a. If YES please explain:____
   ____
   b. Date of last dental exam/X-rays____
   c. Last treating dentist____
6. Yes/No Are you having mouth pain now?
   a. If YES Please explain____
   ____

MEDICATIONS

List ALL Medications you are currently taking. INCLUDING PRECRIPTION, OVER THE COUNTER, SUPPLEMENTS, and HERBAL/NATURAL preparations:____
____
____
____
____

MEDICAL HISTORY:

CIRCLE all that apply:

Medication Allergies (list all allergies below)
____
____

Joint replacement   Need to take antibiotics at the dentist   Pain management Patient

Heart valve replacement   Radiation treatment to head and/or neck   History of Endocarditis

Bad reaction to dental anesthetic   Dental Anxiety

Pregnant/possibility of pregnancy   Breastfeeding

History of taking Osteoporosis Medication ("bisphosphonate drugs" including but not limited to: Actonel (risedronate) Boniva (ibandronate), Reclast (zoledronic), Fosamax (alendronate).

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY)

Heart disease/ heart attack	Reflux/GERD	Stroke	Chemotherapy
Heart defect	HIV/AIDS	Arthritis	Psychiatric Care
Rheumatic fever	Diabetes	Eating disorders	Osteoporosis
High blood pressure	Lung disease	Radiation	Thyroid
Seizures	Kidney disease	Tumor/cancer history	Asthma
Hepatitis	Liver disease	Transplants	Tuberculosis
Canker sores	Herpes	Anemia	Blood thinners
Addiction history	Auto-Immune disease		Sleep apnea

Any other conditions not mentioned:____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLOWING? (PLEASE CIRCLE ALL THAT APPLY)

Chest pain	Headaches	Frequent vomiting
Fainting/dizziness	Unexplained weight loss	Shortness of breath
Fever	Swollen ankles	Joint pain/stiffness
Night sweats	Dry mouth	Sinus problems
Persistant/bloody cough	Excessive thirst	Frequent urination
Bleeding/bruising	Difficulty swallowing	Jaundice
Back pain	Neck pain	Snoring

DENTAL HISTORY (PLEASE CIRCLE ALL THAT APPLY):

Bad breath	Grinding or clenching	Breathing through mouth
Bleeding gums	Jaw pain	Sensitivity to cold
Difficulty chewing	Loose teeth	Sensitivity to heat
Tobacco use	Broken fillings	Sensitivity to sweets
Dry mouth	Cracked teeth	Dentures/partials
Mouth pain	Alcohol use	Sores/growths/blisters

Reason for today's visit:____
____
____
____

How often do you brush?___________________How often do you floss?_____________________________

IN CASE OF EMERGENCY CONTACT:____

Relationship:_______________________________ Home/Cell Phone:________________________________

Work Phone:_______________________________Alternate Phone:_________________________________