WONDER
FAMILY DENTAL & DENTURES

19410 8th Ave NE Suite 102 Poulsbo, WA 98370
Phone: (360) 779-1566 | Fax: (360) 779-6879

MEDICAL & DENTAL HISTORY

Patient Name: _____ DOB: _____ Today's Date: _____

Primary Physician: _____ Date of Last Physical Exam: _____

Office Name: _____ City & State: _____ Phone: _____

Please circle Yes or No (If you answer yes, please fill in the details)

Yes No Are you taking any medication (including over-the-counter and supplements)? Please provide complete list:

_____

Yes No Are you on a daily blood thinner such as Coumadin (warfarin) or aspirin?: If yes, dosage: _____

Yes No Have you ever taken bisphosphonate? If yes, when and how much?: _____

Yes No Have you ever had a joint replacement? If yes, when?: _____ Which joint?: _____

Yes No Are you currently under medical treatment? If yes, what for?: _____

Yes No Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? _____

Yes No Do you use tobacco? If yes, type: _____ How often?: _____

Yes No Do you use controlled substances? If yes, type: _____ How often?: _____

Yes No Are you wearing contact lenses?

Are you allergic to or have you had any reactions to the following?

Yes No Local anesthetics (ex. novocaine)

Yes No Sedatives or sleep-induced drugs

Yes No Latex rubber

Yes No Penicillin or any other antibiotics

Yes No Opioids

Others: _____

Circle any of the medical conditions below that you have had or currently have

Abnormal Bleeding	Hemophilia	Prolonged Bleeding	Anemia
Thyroid Problem	Rheumatic Fever	Leukemia	Glaucoma
Liver Disease (ex: Hepatitis B, C)	Kidney Disease	GERD or Acid Reflux	Eating Disorder
Tumor or Cancer	Radiation Therapy	Chemotherapy	Arthritis
Herpes	Sexually Transmitted Disease	HIV / AIDS	Epilepsy / Convulsion
High Blood Pressure	Low Blood Pressure	Heart Murmur	Cardiac Pacemaker
Mitral Valve Prolapse	Heart Attack	Angina	Congenital Heart Disease
Infective Endocarditis	Prosthetic Heart Valve	Cardiac Transplant	Depression
Anxiety / Nervous Disorder	Dizziness	Bone Disorders	Drug Abuse
Asthma	Emphysema	COPD	Tuberculosis
Pneumonia	Type I Diabetes Mellitus	Type II Diabetes Mellitus	Stroke

CONTINUE ON BACK

Are there any medical conditions we have not discussed that you feel we should be aware of?: _____

_____

Women Only:

Yes No Are you pregnant or think you may be pregnant?

Yes No Are you nursing?

Yes No Are you on any birth control?

Previous Dentist: _____ Date of Last Visit: _____

What was done at that time?: _____ Last Cleaning: _____ Last Exam: _____

What concerns you most about your teeth?: _____

Do you have any dental anxiety?: Yes / No, If yes: please rate your anxiety level (1-10): _____ and what bothers you the most during your dental visit (ex. injection, drill noise): _____

DENTAL HISTORY: Please circle Yes or No (If Yes, please fill in details)

Yes No Are you presently in any dental pain? If yes, where?: _____ Duration: _____

Yes No Are your teeth sensitive to hot or cold liquids or foods? If yes, where?: _____

Yes No Are your teeth sensitive to sweet or sour liquids or foods? If yes, where?: _____

Yes No Are your teeth sensitive to pressure or when you bite down? If yes, where?: _____

Yes No Have there been any injuries to face, mouth or teeth? If yes, where?: _____ When?: _____

Yes No Do you have frequent headaches? Yes No Do you clench or grind your teeth?

Yes No Have you ever been diagnosed with sleep apnea? Yes No Have you ever been tested for sleep apnea?

Yes No Have you ever been diagnosed with TMJD? Yes No Have you ever received treatment for TMJD?

Yes No Have you ever had dry mouth? Yes No Have you ever had orthodontic treatment?

Yes No Have you ever had any difficult extractions in the past?

Yes No Have you ever had any prolonged bleeding following extractions or deep cleaning?

Yes No Do you wear any dental prostheses such as full dentures, partial dentures, bridges, implants, etc.?

Yes No Are you dissatisfied with the appearance of your teeth? If yes, please explain: _____

Yes No Do you have difficulty opening your mouth wide?

Yes No Do you have difficulty with gagging when impressions are taken?

Yes No If you have missing teeth, are you interested in discussing implant options with the dentist?

Yes No Are you interested in teeth whitening?

Have you ever experienced any of the following problems in your jaw (TMJ)?

Yes No Clicking Yes No Pain (joint, ear, side of face)

Yes No Difficulty opening or closing Yes No Difficulty chewing

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the denturist/dentist/hygienist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payouts and/or health practitioners.

Patient/Parent/Guardian Signature: _____ **Date:** _____