STONEBRIDGE RANCH DENTISTRY

TEXAS PEDIATRIC DENTISTRY

TPD Smiles

MEDICAL HISTORY FOR: _____ DOB: _____

(Please print patient's full name)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's/psychiatrist's care now?	Y N	Have you ever been hospitalized or had a major operation?	Y N
Have you ever had a serious head or neck injury?	Y N	Are you taking any medications, pills, or drugs?	Y N
Are you on a special diet?	Y N	Do you use tobacco, vape, or are frequently exposed to tobacco smoke?	Y N
Do you use controlled substances?	Y N	Do you take, or are scheduled to take, IV or oral bisphosphonates?	Y N
Do you have impaired vision, hearing, or speech?	Y N		

If yes to any of the above questions, please explain: _____

Women: Are you pregnant/trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

Do you have, or have you had, any of the below conditions?

Artificial (prosthetic) heart valve	Y N	Congenital heart disease (CHD)	Y N		
Previous infective endocarditis	Y N	Unrepaired, cyanotic CHD	Y N		
Damaged valve in transplanted heart	Y N	Repaired CHD (completely) in last 6 months	Y N		
		Repaired CHD with residual defects	Y N		

*****Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD*****

AIDS/HIV Positive	Y N	Eating Disorder	Y N	Kidney Problems	Y N
Anemia	Y N	Emphysema	Y N	Mitral Valve Disease	Y N
Angina	Y N	Epilepsy or Seizures	Y N	MRSA	Y N
Arthritis/Gout	Y N	Fainting Spells/Dizziness	Y N	Osteoporosis	Y N
Artificial Heart Valve	Y N	Frequent Cough	Y N	Parathyroid Disease	Y N
Artificial Joint	Y N	Frequent Diarrhea	Y N	Radiation Treatments	Y N
Asthma/Breathing problem	Y N	Glaucoma	Y N	Unexplained Weight Loss/Gain	Y N
Attention Deficit Hyperactivity Disorder (ADHD)	Y N	Heart Attack/Failure	Y N	Renal Dialysis	Y N
Autism/Autism Spectrum Disorder	Y N	Heart Murmur	Y N	Rheumatic Fever	Y N
Blood Disease	Y N	Heart Pace Maker	Y N	Rheumatism	Y N
Blood Transfusion	Y N	Heart Trouble/Disease	Y N	Scarlet Fever	Y N
Bruise Easily	Y N	Hemophilia	Y N	Sickle Cell Disease	Y N
Cancer	Y N	Hepatitis A	Y N	Sinus Trouble	Y N
Chemotherapy	Y N	Hepatitis B or C	Y N	Sleep Apnea	Y N
Chest Pains	Y N	Herpes	Y N	Stomach/Intestinal Disease	Y N
Cortisone Medicine	Y N	High Blood Pressure	Y N	Stroke	Y N
Cystic fibrosis	Y N	Hives or Rash	Y N	Swelling of Limbs	Y N
Depression/Anxiety	Y N	HPV	Y N	Thyroid Disease	Y N
Developmental disorders, learning problems or delays, Intellectual disability	Y N	Hydrocephaly or Shunt	Y N	Tumors or Growths	Y N
Diabetes (Type I or Type II)	Y N	Hypoglycemia	Y N	Ulcers	Y N
Drug Addiction	Y N	Irregular Heartbeat	Y N	Sensory processing issues	Y N
Easily Winded	Y N	Jaundice/Liver Problems	Y N	Sexually Transmitted Disease	Y N

~OVER~

Do you have any of the following diseases or problems?

Active tuberculosis	Y	N
Persistent cough greater than a 3-week duration	Y	N
Cough that produces blood	Y	N
Been exposed to anyone with tuberculosis	Y	N

If you answer yes to any of the 4 items above, please return this form to the receptionist immediately.

Are you allergic or have you had a reaction to any of the following?

Animals	Y	N	Gluten	Y	N	Local anesthetics	Y	N
Aspirin	Y	N	Hay fever/Seasonal	Y	N	Metals	Y	N
Barbiturates, sedative, or sleeping pills	Y	N	Iodine	Y	N	Penicillin or other antibiotics	Y	N
Codeine or other narcotics	Y	N	Lactose	Y	N	Sulfa Drugs	Y	N
Food	Y	N	Latex (Rubber)	Y	N	Other: _____	Y	N

Have you ever had an anaphylactic reaction to any of the above allergies? If YES, which one? _____

If you answered YES to any of the above conditions on this page or the previous, or if you have had another serious illness not listed above, please explain _____

_____

_____

DENTAL INFORMATION AND HISTORY

What is the reason for your dental visit today? New Patient Routine cleaning Tooth pain/problem Other: _____

What is the most important thing to you about your future smile and dental health? _____

Do you use fluoride toothpaste? YES NO

Have you experienced any unfavorable reaction from previous dental care? YES NO

Do you have, or have you had, any of the following conditions?

Bad breath	Y	N	Grinding or clenching teeth	Y	N	Periodontal (gum) treatments	Y	N
Braces/Orthodontics	Y	N	Headaches	Y	N	Sensitivity (hot, cold, sweets, pressure) Where? Upper Lower / Right Left	Y	N
Bleeding, swollen, or irritated gums	Y	N	Jaw joint pain	Y	N	Sleep Apnea	Y	N
Dry Mouth	Y	N	Loose, tipped, or shifting teeth	Y	N	Teeth or fillings breaking	Y	N
Excessive gagging	Y	N	Mouth breathing	Y	N	Other: _____	Y	N

If you could change your smile, you would:

Make it whiter	Y	N	Replace black metal fillings with tooth colored restorations	Y	N	Replace missing teeth	Y	N
Make it straighter	Y	N	Repair chipped teeth	Y	N	Have a smile makeover	Y	N
Close spaces	Y	N	Replace old crowns that do not match	Y	N	Other: _____ _____	Y	N

IF NEW PATIENT:

Name of previous dentist _____ Date of last visit _____ Last cleaning _____

ORAL CANCER SCREENING

The CDC recommends an annual oral cancer screening exam. Delays in screening could put you at risk of oral cancer not being detected at an early stage; oral cancer is often painless in the early stages. We have recently incorporated VELscope into our oral screening standard of care. We find that using VELscope along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope is similar to other proven early detection procedures for other types of cancer. It is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. The whole exam should only take 5 additional minutes.

This enhanced examination is recognized by the American Dental Association; however, this exam will not likely be covered by your insurance. **The fee for this examination is $20**, payable at the time the service is rendered.

☐ **YES** I authorize the clinician to perform the VELscope exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

☐ **NO** I decline the VELscope exam at this time.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes to medical status.

_____ _____

Patient/Parent/Guardian Signature Date