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BELMAR PARK DENTAL CARE, P.C.

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David G. Collins, DDS, FICOI

MEDICAL HISTORY UPDATE

Your Name _____ Today's Date _____

Physician's Name _____ Phone # _____

Are you under a doctor's care now? Why? _____ YES NO

Have you been hospitalized during the past two years? Why?_____ YES NO

Are you taking any medications, pills, or drugs? What? _____ YES NO

Please list any allergies to drugs, medications, anesthetics or latex_____

Please tell us if you have had any of the following by checking the appropriate box

- ☐ Bacterial Endocarditis
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Rheumatic Heart Fever
- ☐ Rheumatic Heart Disease
- ☐ Artificial Heart Valves
- ☐ Congenital Heart Lesion
- ☐ Heart Attack____year
- ☐ Angina/Chest Pain
- ☐ Heart Pacemaker____year
- ☐ Heart Surgery____year
- ☐ Congestive Heart Failure
- ☐ Stomach Problems/Reflux
- ☐ Hemophelia
- ☐ Blood Disease
- ☐ Sickle Cell Anemia
- ☐ Anemia/Blood Problems
- ☐ Excessive Bleeding
- ☐ Asthma
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Eye Disorders/Glaucoma
- ☐ AIDS/HIV
- ☐ Immunosupressive Disorders/ARC
- ☐ Any Artificial Replacement Artifical Knee, Hip, Joint, Pins, Plate____year
- ☐ Rheumatism/Arthritis
- ☐ Neurological Problems
- ☐ Epilepsy/Seizures
- ☐ Psychiatric Problems
- ☐ Emotional Problems
- ☐ Alcoholism
- ☐ Chemical Dependency
- ☐ Drug Addiction
- ☐ Tobacco Use
- ☐ Malignancies
- ☐ Cancers, Tumors, Growths
- ☐ Radiation Treatments
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Dialysis
- ☐ Liver Problems
- ☐ Hepatitis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcer/Colitis
- ☐ Venereal Disease
- ☐ Herpes
- ☐ Fever Blisters
- ☐ Latex Allergy
- ☐ Pregnant____months
- ☐ Planning to be pregnant soon
- ☐ Oral Contraceptives

Have you ever taken medication for osteoporosis or to improve bone density?_____ YES NO

Please list any other MEDICAL CONDITIONS not mentioned above _____

DENTAL HISTORY

How long since your last dental visit?_____What was done at this time? _____

Previous dentist's name _____ Phone # _____

	YES	NO	NA
Have you made regular dental visits?	☐	☐	☐
Were dental x-rays taken recently?	☐	☐	☐
Do you have a current pano or full mouth series?	☐	☐	☐
Have you lost any teeth or have any teeth been removed?	☐	☐	☐
Would you like to know about permanent replacements?	☐	☐	☐
Have you ever had any problems or complications with previous dental treatment?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Does your jaw click or pop?	☐	☐	☐
Have you experienced any pain or soreness in the muscles of your face or around your ear?	☐	☐	☐
Do you have frequent headaches, neckache or shoulder aches?	☐	☐	☐
Does food get caught in your teeth?	☐	☐	☐
Are any of your teeth sensitive to Hot, Cold, Sweets, and or pressure?	☐	☐	☐

	YES	NO	NA
Have your wisdom teeth been removed	☐	☐	☐
Do your gums bleed or hurt?	☐	☐	☐
How often do you brush your teeth?	1x	2x's	3x's a day
Do you use dental floss?	☐	☐	☐
Are any of your teeth loose, tipped, shifted or chipped?	☐	☐	☐
Are you unhappy with the appearance of your teeth?	☐	☐	☐
Do you feel your breath is offensive at times?	☐	☐	☐
Have you ever had gum treatment or surgery?	☐	☐	☐
Have you had any orthodontic work?	☐	☐	☐

How do you feel about your teeth in general? _____

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____

Do you have any questions or concerns? _____

_____

_____

_____ _____

Patient's (Guardian's) Signature Date