Pursuing the Perfect Smile

Stephen G. Petinge, D.M.D.

Complete Esthetic Dentistry

MEDICAL HISTORY

Name:_____

Email: _____

Best contact # _____

Describe chief dental concern: _____

Please mark either:	Yes	No
Do you feel discomfort in your teeth or jaw when chewing?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you feel you chew efficiently?	☐	☐
Have you had poor experience with dentistry?	☐	☐
Are you interested in saving your teeth?	☐	☐
Do any members of your family wear dentures?	☐	☐
Do your gums bleed when chewing or brushing?	☐	☐
Are you pleased with the appearance of your teeth?	☐	☐
Are you deeply concerned about the Finances required to return your mouth to excellent dental health?	☐	☐

If you could change anything about your teeth, what would you change? _____

_____

Are you under the care of a physician? ☐ ☐

Why? _____

_____

List any medications, prescribed or self administered:

_____

_____

_____

DOB: _____

Do you have or have you had any of the following:

	Yes	No
Mitral Valve Prolapse	☐	☐
Heart Disease	☐	☐
Rheumatic Fever	☐	☐
Angina (chest pain)	☐	☐
Artificial Joint Replacement	☐	☐
High or Low Blood Pressure	☐	☐
Stroke	☐	☐
Kidney Trouble	☐	☐
Arthritis	☐	☐
Diabetes	☐	☐
Tuberculosis	☐	☐
Malignancies (cancer)	☐	☐
AIDS or any related illness (HIV Virus)	☐	☐
Asthma or Emphysema	☐	☐
Productive Cough or Recent Cold	☐	☐
Hayfever, Allergies or Hives	☐	☐
Liver Disease, Jaundice, Hepatitis	☐	☐
Thyroid Disease	☐	☐
Epilepsy, Seizures, Convulsions	☐	☐
Difficulty in Hearing or Eye Disease	☐	☐
Psychiatric or Nervous Disorders	☐	☐
Do you smoke? If so how many packs per day ____		
Sinus Trouble	☐	☐
Excessive or Prolonged Bleeding	☐	☐
Anemia or Blood Disorder	☐	☐
Latex Allergy	☐	☐
Do you have allergies to any Medications?	☐	☐
Penicillin	☐	☐
Local Anesthesia (Novocaine etc.)	☐	☐

Any other Drugs _____

List Medications you have allergies to:

_____

_____

Past Surgeries (last 5 years) _____

_____

Pre Medication required by Physician? ☐ ☐

WOMEN

Are you taking medication for osteoporosis?	☐	☐
Pregnant? If so what month?	☐	☐
Are you taking birth control pills?	☐	☐

THE ABOVE MEDICAL HISTORY IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO ROUTINE PROCEDURES DEEMED NECESSARY FOR DIAGNOSIS AND TREATMENT.

Signature of Patient or Guardian_____ Date _____