Patient Name: _____ Date: _____

MEDICAL HISTORY

It is important for us to know your medical, dental and medication history as they can have a direct bearing on any treatment we may render to you. The information you provide will allow us to better meet your medical/dental concerns. Our staff will be happy to assist you in completing these forms as needed.

In your own words, what are your chief dental/medical complaints if any?

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Please list all physicians, osteopaths, dentists, physical therapists, chiropractors, hospitals, clinics who have been involved in the problems for which you are seeking treatment.

Physician Name _____ Address_____ Phone_____
Physician Name _____ Address_____ Phone_____
Physician Name _____ Address_____ Phone_____

Height: _____ins **Weight** _____lbs.

Do you have: (please√) **Dr. Reviewing Histories: _____ Signature: _____**

NO	PAST	NOW		NO	PAST	NOW		NO	PAST	NOW	
❑	❑	❑	Allergies	❑	❑	❑	Fibromyalgia	❑	❑	❑	TB/Lung Disease
❑	❑	❑	Asthma	❑	❑	❑	Swollen Hands/Feet	❑	❑	❑	HIV/Aids
❑	❑	❑	Hay Fever	❑	❑	❑	Cold Hands/Feet	❑	❑	❑	Venereal Disease
❑	❑	❑	Sinus Problems	❑	❑	❑	Brittle Nails	❑	❑	❑	Prostate Problem
❑	❑	❑	Frequent Colds	❑	❑	❑	Skin Rash	❑	❑	❑	Painful/Frequent Urination
❑	❑	❑	Chronic Cough	❑	❑	❑	Dry Skin	❑	❑	❑	Impotence
❑	❑	❑	Snoring	❑	❑	❑	Emotional Upsets	❑	❑	❑	Menstrual Cramps (severe)
❑	❑	❑	Sleep Apnea	❑	❑	❑	Nervous Breakdown	❑	❑	❑	Pregnancy
❑	❑	❑	Dry Mouth	❑	❑	❑	Learning Disability	❑	❑	❑	Birth Control
❑	❑	❑	Mouth Breathing	❑	❑	❑	ADHD	❑	❑	❑	Menopausal Problems
❑	❑	❑	Tongue Thrust	❑	❑	❑	Psychological Care	❑	❑	❑	Muscular Dystrophy
❑	❑	❑	Enlarged Tonsils	❑	❑	❑	Memory Loss	❑	❑	❑	Multiple Sclerosis
❑	❑	❑	Swallowing Problems	❑	❑	❑	Depression	❑	❑	❑	Parkinson Disease
❑	❑	❑	Cold Sores	❑	❑	❑	Perfectionist	❑	❑	❑	Hand Tremors
❑	❑	❑	Nose Bleeds	❑	❑	❑	Poor Digestion	❑	❑	❑	Shaking/Twitching
❑	❑	❑	Earaches/Infections	❑	❑	❑	Laxative Use	❑	❑	❑	Seizures/Epilepsy
❑	❑	❑	Hearing Loss	❑	❑	❑	Diarrhea	❑	❑	❑	Cancer
❑	❑	❑	Vision Problems	❑	❑	❑	Constipation	❑	❑	❑	Chemo/Radiation
❑	❑	❑	Glaucoma	❑	❑	❑	Hemorrhoids	❑	❑	❑	Biophosphonate Therapy
❑	❑	❑	Tension Headaches	❑	❑	❑	Ulcers/Stomach Problems	❑	❑	❑	Heart Disease
❑	❑	❑	Migraine Headaches	❑	❑	❑	Gastric Reflux	❑	❑	❑	Heart Murmur
❑	❑	❑	Back Ache	❑	❑	❑	Stomach Gas	❑	❑	❑	Pacemaker
❑	❑	❑	Neck Ache	❑	❑	❑	Gall Bladder Problems	❑	❑	❑	Artificial Heart Valve
❑	❑	❑	Arthritis	❑	❑	❑	Heartburn	❑	❑	❑	Arteriosclerosis
❑	❑	❑	Scoliosis	❑	❑	❑	Diabetes	❑	❑	❑	Varicose Veins
❑	❑	❑	Artificial Limb/Joint	❑	❑	❑	Hypothyroidism	❑	❑	❑	Hypertension
❑	❑	❑	Chronic Pain	❑	❑	❑	Hypoglycemia	❑	❑	❑	Anemia/Blood Disorders
❑	❑	❑	Facial Pain	❑	❑	❑	Kidney Disease	❑	❑	❑	Abnormal Bleeding
❑	❑	❑	Muscle Spasm	❑	❑	❑	Liver Disease	❑	❑	❑	CVA/Stroke
❑	❑	❑	Dizziness	❑	❑	❑	Hepatitis	❑	❑	❑	Insomnia
❑	❑	❑	Fatigue	❑	❑	❑	Scarlet Fever	❑	❑	❑	Under/Over Weight
❑	❑	❑	Fainting Spells	❑	❑	❑	Rheumatic Fever	❑	❑	❑	Other _____
❑	❑	❑	Numb Fingers	❑	❑	❑	Polio				_____

Medications/Supplements

Do you take over the counter/prescription drugs/supplements? ❑Yes ❑No

Drug Taken:_____Reason:_____
Drug Taken:_____Reason:_____
Drug Taken:_____Reason:_____
Drug Taken:_____Reason:_____
Drug Taken:_____Reason:_____

Are you currently taking blood thinners such as Coumadin? ❑Yes ❑No
Are you on an aspirin regime? ❑Yes ❑No
Have you ever been pre-medicated for dental treatment with an antibiotic? ❑Yes ❑No
If yes for what reason? _____
Have you ever taken Fen-Phen, Pondimin or Redux? ❑Yes ❑No
Are you allergic to <u>Latex?</u> ❑Yes No❑ **Do you have skin allergies to metal?** ❑Yes No❑

Are you allergic to any medications or have you had an adverse reaction to any? ❑Yes No❑
❑Penicillin ❑Erythromycin ❑Codeine ❑Novocain ❑Aspirin ❑Vicodin ❑Valium ❑Nitrous oxide
❑Other _____

Have any family members had the following and what is their relationship to you?

	Relationship		Relationship
❑ Cancer	_____	❑ Heart Attacks	_____
❑ Stroke	_____	❑ Diabetes	_____
❑ Alcoholism	_____	❑ Migraines	_____

Have you had a major illness? ❑Yes No❑
What was it? _____ Have you been hospitalized? ❑Yes No❑
When _____ For what reason? _____
How are you now? _____ When_____
Are there any other health concerns that we should be aware of? _____
Please describe any regular exercise you do: _____

For women: Are you pregnant? ❑Yes ❑No Due Date: _____

HABITS +
Habits have an affect on our physical and dental health. Please check all that apply to you.

NO PAST NOW	NO PAST NOW	NO PAST NOW
❑ ❑ ❑ 3+ hrs. TV per day	❑ ❑ ❑ Recreational Drugs	❑ ❑ ❑ Chew on Ice
❑ ❑ ❑ Chew Tobacco	❑ ❑ ❑ Nail Biting	❑ ❑ ❑ Thumb Sucking
❑ ❑ ❑ Cigarettes	❑ ❑ ❑ Chew Lips/Cheeks	❑ ❑ ❑ Alcohol x's pr day _____ x's pr wk _____

DENTAL HISTORY

Previous Dentist_____ Phone_____

_____

Address City State Zip

Date of last dental visit _____

Date of last Full Mouth X-rays_____

Date of last hygiene (preventive) appointment _____

Do we have your permission (release) to request records? Yes ❑ No ❑

_____

Pt signature:

Please check any of the following that applies to you.

NO PAST YES

❑ ❑ ❑ Are you afraid of dental treatment? Reason_____

❑ ❑ ❑ Do you have bad breath problems?

❑ ❑ ❑ Are you unhappy with the appearance of your teeth? Reason_____

❑ ❑ ❑ Are you fearful of losing your natural teeth in your lifetime?

❑ ❑ ❑ Do you have difficulty chewing on both sides of your mouth?

❑ ❑ ❑ Have you been unhappy with your previous dental treatment? Reason_____

❑ ❑ ❑ Dental Implants

Do you brush your teeth daily? ❑ Yes ❑ No How often do you brush? _____

Do you floss? ❑ No ❑ Yes How often?_____

Do you have: (please✓)

NO PAST NOW

❑ ❑ ❑ Discomfort in right jaw joint

❑ ❑ ❑ Discomfort in left jaw joint

❑ ❑ ❑ Tired or tense jaw muscles

❑ ❑ ❑ Excessively warm jaw muscles

❑ ❑ ❑ Painful teeth

❑ ❑ ❑ Tic or nervous twitch

❑ ❑ ❑ Over closed bite

❑ ❑ ❑ Difficulty in opening mouth wide

❑ ❑ ❑ Jaw locking open

❑ ❑ ❑ Jaw locking shut (closed)

❑ ❑ ❑ Discomfort in opening jaw

❑ ❑ ❑ Muscle soreness when jaw is open for long periods

❑ ❑ ❑ Jaw swings to side when opening

❑ ❑ ❑ Grind teeth

NO PAST NOW

❑ ❑ ❑ Frequent headaches, neck aches

❑ ❑ ❑ Clench teeth

❑ ❑ ❑ Facial muscle soreness in morning

❑ ❑ ❑ Bite cheeks, lips, tongue while eating

❑ ❑ ❑ Teeth sensitive to temperature changes

❑ ❑ ❑ Loose or drifting teeth

❑ ❑ ❑ Swelling in gums

❑ ❑ ❑ Orthodontic Treatment

❑ ❑ ❑ Periodontal Treatment

❑ ❑ ❑ Salty Taste

❑ ❑ ❑ Copper or metal taste

❑ ❑ ❑ Changes in salivation

❑ ❑ ❑ Tearing for no reason

❑ ❑ ❑ Pressure behind eyes

Do you have frequent pain in the head and/or neck? ❑Yes ❑No

What area of the head? _____ **When did head/neck pain begin? _____**

How often does pain occur? _____ **How long does pain last? _____**

Please describe any positioning of the jaw that helps to relieve pain. _____

Have you been in an auto accident? ❑Yes ❑No

When? _____

Describe: _____

Have you had any injury to the head/face? ❑Yes ❑No

When? _____

Describe: _____

Please indicate anything else about yourself that you suspect may be related to your condition.

_____

Describe any emotional problems you have regarding your teeth. _____

_____

Do any of the following daily activities cause you any pain or discomfort?

- ❑ Yawning
- ❑ Swallowing
- ❑ Speaking
- ❑ Singing
- ❑ Shouting
- ❑ Brushing Teeth
- ❑ Turning neck
- ❑ Turning head
- ❑ Turning trunk
- ❑ Turning arms
- ❑ Moving shoulder

Indicate pain types you experience

- ❑ Sharp ❑ Deep ❑ Diffused ❑ Cyclic
- ❑ Dull ❑ Superficial ❑ Constant
- ❑ Aching ❑ Throbbing ❑Intermittent

What is the intensity of your pain? _____
(1 = no pain, 5 = worse pain)

Do you ever notice any of the following in either of your ears or in the jaw joint?

R	L		R	L	
❑	❑	Hearing loss	❑	❑	Hearing sensitivity
❑	❑	Popping Noises	❑	❑	Grating
❑	❑	Stuffiness	❑	❑	Ear infections
❑	❑	Ringing	❑	❑	Tubes in ears
❑	❑	Itching feeling	❑	❑	Other

SMILE SURVEY

Our smile. All of us have one. Your smile is one thing that can bring you Confidence! Some of us are less confident with our smile because it may have on or two obvious (but correctable) imperfections. Are you concerned about any of these dental conditions?

- ❑ Yellow Teeth
- ❑ Stained Teeth
- ❑ Missing Teeth
- ❑ Cracked/Broken Teeth
- ❑ Red/swollen/bleeding Gums
- ❑Chipped Teeth
- ❑ Uneven Edges
- ❑ Crooked Teeth
- ❑ Crowded Teeth

These modern methods have won New Confidence for…

Children Teens Adults Seniors

- ❖ Whitening
- ❖ Bonding
- ❖ Tooth Colored Fillings
- ❖ Porcelain Veneers
- ❖ Crowns
- ❖ Bridges
- ❖ Orthodontics

CONSENT FOR TREATMENT

I hereby state that the medical and dental histories are correct to the best of my knowledge.
I authorize routine dental **diagnostic** procedures which may include x-rays and photographs. I understand that any x-rays taken become part of the permanent record of Darryl K. Ragland, DDS. I also understand that these x-rays and photographs belong to the dentist, but they may be transferred to another dentist or forwarded to my insurance carrier upon request. I further understand that a duplication fee may apply and that I am responsible for any such fees.
I understand that any dental treatment prescribed will be listed separately from this document. Treatment will be explained, and I will be given a written estimate for such treatment for consideration, and I have the right to refuse any treatment so prescribed.

I agree to the use of anesthetics and medications considered necessary by Darryl K. Ragland, DDS and/or his associates.

Signature_____ Date_____
Patient or responsible person