BROOKWOOD
DENTISTRY

Patient _____ Date of Birth _____

# MEDICAL HISTORY

1. Are you allergic to or have you had a reaction to: Penicillin or Other Antibiotics_____ Local Anesthetics_____
   Aspirin_____ Codeine_____ Latex_____ Acrylic_____ Metal_____Sulfa Drugs_____ Any other _____
2. Are you presently taking any drugs or medications (OTC or prescribed)? ☐ Yes ☐ No
   If so, What? _____
   _____
3. Do you need pre-medication for dental procedures? _____ If YES, for what condition? _____
4. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? _____ If so, date: _____
5. Are you presently under the care of a physician? _____ If YES, for what condition? _____
   Physicians name and phone number: _____ Date of Last Exam: _____
6. Have you ever been hospitalized (except for pregnancy)? _____ If YES, please explain: _____
7. Have you ever had major surgery? _____ If YES, please explain: _____
8. Are you Pregnant? _____ Are you nursing? _____ Are you taking birth control or hormone replacements? _____
9. Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? _____
   If so, for how long? _____

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

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Cardiovascular Disease | ☐ | ☐ | Organ Transplant If yes, specify: _____ |
| ☐ | ☐ | Angina | ☐ | ☐ | Acid Reflux/GERD |
| ☐ | ☐ | Arteriosclerosis | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Congestive Heart Failure | ☐ | ☐ | Fainting Spells or Seizures |
| ☐ | ☐ | Damaged Heart Valves | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Prosthetic Heart Valves | ☐ | ☐ | Anemia If so, specify: _____ |
| ☐ | ☐ | Heart Attack If yes, date: _____ | ☐ | ☐ | Abnormal Bleeding |
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | Blood Transfusion If yes, date: _____ |
| ☐ | ☐ | Rheumatic Heart Disease | ☐ | ☐ | Hemophilia |
| ☐ | ☐ | Other Congenital Heart Defects | ☐ | ☐ | Kidney Problems If yes, specify: _____ |
| ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Severe Headaches/Migraines |
| ☐ | ☐ | Infective Endocarditis | ☐ | ☐ | Eating Disorder |
| ☐ | ☐ | Pacemaker | ☐ | ☐ | Diabetes Type 1 or 2 |
| ☐ | ☐ | Rheumatic Fever | | | Last Known HbA1c: _____ Date: _____ |
| ☐ | ☐ | Rheumatic Heart Disease | ☐ | ☐ | Arthritis |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Thyroid Problems or Goiter |
| ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Stomach Ulcers |
| ☐ | ☐ | Stroke If yes, date: _____ | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Autoimmune Disease | ☐ | ☐ | Nervous Condition |
| ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | Convulsions or Epilepsy |
| ☐ | ☐ | Systemic Lupus Erythematosus | ☐ | ☐ | AIDS or HIV Infection |
| ☐ | ☐ | Asthma | ☐ | ☐ | Hepatitis, Jaundice or Liver Disease |
| ☐ | ☐ | Bronchitis | ☐ | ☐ | Cancer |
| ☐ | ☐ | Emphysema | ☐ | ☐ | Treated with Radiation or Chemotherapy |
| ☐ | ☐ | Sinus Trouble | | | If yes, dates of treatment: _____ |
| ☐ | ☐ | Chronic Pain | ☐ | ☐ | Sexually Transmitted Disease |
| ☐ | ☐ | Glaucoma | ☐ | ☐ | Other Not Listed: _____ |

Signature _____ Date _____

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# DENTAL and SLEEP HISTORY

1. Nature of visit: _____
2. Are you experiencing pain or discomfort? _____
3. Are you fearful of dental treatment? No____ A Little ____ A Lot____ Extreme_____
4. What is the worst part of dental treatments? _____
5. Have you had any serious trouble associated with any previous dental treatment? _____
   If so, explain: _____
6. Last visit to a dentist: _____ Dentist's name and phone number: _____
   What was done at that time? _____
7. Are you on Gwinnett County Water _____ Well Water_____ Other_____
8. Have you had past periodontal treatment? _____ If so, please explain: _____
9. Have you had orthodontic treatment? _____ If so, when? _____
10. Have you been diagnosed with sleep apnea or wear a CPAP? _____
    If so, please explain: _____
11. Do you have sleep problems? _____
    If yes, please explain: _____
12. Do you snore? _____
13. Do you have trouble staying awake or falling asleep? _____
    If yes, please explain: _____
14. Have you been diagnosed with a Calcium deficiency? _____
15. Do you have any dietary restrictions (i.e. vegetarian, etc.)? _____

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

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Bleeding Gums |
| ☐ | ☐ | Sensitivity to Cold, Heat, Sweets, or Pressure |
| ☐ | ☐ | Dry Mouth |
| ☐ | ☐ | Mouth Sores or Ulcers |
| ☐ | ☐ | Clenching or Grinding |
| ☐ | ☐ | Serious Injury to Head or Mouth |

Do you use any of the following:

| Yes | No | | |
|---|---|---|---|
| ☐ | ☐ | Tobacco (smoking, snuff, chew) | Frequency: _____ |
| ☐ | ☐ | Vaping | |
| ☐ | ☐ | Alcoholic Beverages | Frequency: _____ |

Signature _____ Date _____

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Signature _____ Date _____