WHITNEY M. FRANK
DDS

Patient Name_____
Date of Birth _____ **Today's Date** _____

Although dental personnel primarily treat only your mouth, the mouth is a part of your entire body. Health problems that you may have or medication that you are taking could have a significant impact on the dental care you will receive. Thank you in advance for answering the following questions.

Please list your family physician and any medical specialists you see at least once a year:

NAME SPECIALTY PHONE NUMBER

_____

_____

_____

YES NO Do you consider yourself to be in good health?
YES NO Have you ever needed premedication with antibiotics prior to dental care?

Please list any history of hospitalization or surgery and the date: _____

_____

Do you **currently have** or have you **ever had**:

YES NO Allergic reactions to: Latex Penicillin Codeine Local Anesthetics Metals Other: _____
Reaction: _____
YES NO Heart Attack Date:_____
YES NO Heart Bypass, Stent or Artificial Heart Valve Type:_____ Date_____
YES NO Stroke Date_____

YES NO Irregular Heartbeat
YES NO Pacemaker
YES NO High Blood Pressure
YES NO Congestive Heart Failure
YES NO Rheumatic fever, rheumatic heart disease or bacterial endocarditis
YES NO Diabetes Type I or Type II Most recent HbA1c: _____

YES NO GERD or acid reflux
YES NO Anorexia or Bulimia
YES NO Thyroid disease
YES NO Kidney Disease
YES NO Artificial Joint or Implant Joint: _____ Date: _____
YES NO Arthritis (type:_____)
YES NO Bleeding or clotting disorder
YES NO Seizures or any other nervous system disease
YES NO Hepatitis A, B, C or D or other liver disease
YES NO Asthma, tuberculosis, shortness of breath or other lung disease
YES NO Cancer Type_____
Chemotherapy (dates) _____ Radiation (dates) _____

YES NO Immunosuppressive condition or treatment such as: Prednisone therapy, HIV/AIDS, Organ Transplant
YES NO Impairment of hearing or sight or speech
YES NO Physical or mental condition that may require special care
YES NO Sleep Apnea AHI: _____
YES NO Are you able to use a CPAP effectively to treat sleep apnea?

YES NO Have you been told that you snore?
YES NO Do you experience daytime drowsiness?
YES NO Have you ever been told that you stop breathing at times while you sleep?
YES NO Are you or could you be pregnant? Currently Breastfeeding?

YES NO Are you being treated with or have you undergone osteoporosis therapy? Boniva Actonel Fosamax Reclast Zometa
YES NO Any significant history of recreational drug use?
YES NO Do you have any disease, condition, or problem not listed here? Please describe: _____
YES NO History of or currently smoking? Packs/day: _____ For how many years? _____ Quit date (if applicable): _____
YES NO History of or current use of smokeless tobacco?
YES NO How interested are you in discontinuing tobacco use? Very Somewhat Not at all
Methods previously used to quit tobacco use: _____

Dental History

Why are you seeking dental care? _____
How often do you typically have dental exams and cleanings: _____
Date of last exam: _____
What type of toothbrush do you use: _____
How often do you brush your teeth: _____ How often do you floss: _____
YES NO Do you want to keep your teeth for your lifetime?
YES NO Are you happy with the appearance of your smile?
YES NO Have you had any trouble associated with previous dental treatment?
If so, please explain: _____
YES NO Has fear ever prevented you from seeking dental treatment?
YES NO Have you ever injured your face or jaw?
YES NO Are you allergic to any metals or dental materials?
YES NO Have you noticed any lumps or sores in your mouth?
YES NO Do you get **cold sores** or **canker sores**? How many times a year? _____
YES NO Have you ever been advised about periodontal disease, or been treated for periodontal disease?
YES NO Do your gums bleed at any time?
YES NO Have you ever worn a night guard or mouth splint?
YES NO Have you ever had TMJ pain?

_____
_____

Please circle the types of dental treatment or procedures you have had:

Orthodontics Root Canal Treatment Tissue Graft Implant Oral Surgery
Fillings TMJ treatment Periodontal (gum) surgery Dentures Crowns

If you could wave a magic wand and change one thing about your smile, what would it be: _____
_____

Please complete the following medication list, and then sign below:

Dr. Frank requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside of this office will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and keep you safe during dental treatment. By signing below, you agree that the information given is accurate and that you will notify us of any changes at subsequent appointments.

Patient signature: _____ Date:_____
Or patient representative: _____ Relationship to patient:_____

Please list all medicines and supplements (including natural or herbal) that you are currently taking.

Date	Medicine or Supplement	Dose	Medical Condition	Date Discontinued	Notes