Cordido Dental Pros

Your Healthy and Customized Smile.

MEDICAL AND DENTAL HISTORY

Patient Name: _____ DOB: ____/____/_____
Last First Middle

Gender _____ Height: _____ Weight:_____ Glucose: _____ A1c (if diabetic): _____

General Health History

Cardiovascular Conditions
- ☐ Angina
- ☐ Atherosclerosis
- ☐ Artificial heart valve
- ☐ Internal defibrillator
- ☐ Heart attack
- ☐ Heart murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congenital heart disease
- ☐ Mitral valve prolapse
- ☐ Bypass surgery
- ☐ Pacemaker

Respiratory Conditions
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Asthma
- ☐ Seasonal Allergies
- ☐ Sinusitis
- ☐ COPD

Gastrointestinal Conditions
- ☐ Colon Disorders
- ☐ Persistent diarrhea
- ☐ Difficulty swallowing
- ☐ Gastroesophageal reflux
- ☐ Ulcers
- ☐ Malnutrition
- ☐ Jaundice
- ☐ Gallbladder stones/issues
- ☐ Liver disease
  - ☐ Hepatitis A B C
  - ☐ Cirrhosis
  - ☐ Other

Endocrine Conditions
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Other thyroid problems
- ☐ Parathyroid conditions
- ☐ Diabetes Type_____
- ☐ Hypoglycemia

Genitourinary Conditions
- ☐ Kidney problems
- ☐ Frequent urinary infections
- ☐ Bladder infection
- ☐ Dialysis

Infectious disease
- ☐ Type _____

Cancer
- ☐ Site:_____
- ☐ Surgery date: _____
- ☐ Chemo _____
- ☐ Radio _____

Bone & Joint Conditions
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Trauma/frequent fractures
- ☐ TMJ problems
- ☐ Jaw Surgery

Bleeding abnormalities
- ☐ Prolonged bleeding
- ☐ Anemia
- ☐ Sickle cell disease trait_____
- ☐ Hemophilia type _____
- ☐ Blood transfusion

Neurologic Conditions
- ☐ Epilepsy
- ☐ Convulsions/ seizures
- ☐ Stroke
- ☐ Neuritis
- ☐ Neuralgia/tics
- ☐ Numbness/Paralysis
- ☐ Severe headaches Frequency _____
- ☐ Migraines
- ☐ Repeated blackouts or fainting
- ☐ Chronic facial pain

Psychologic Treatment
- ☐ Depression
- ☐ Anxiety
- ☐ Panic disorders
- ☐ Eating disorders
- ☐ Other _____

Dermatologic Conditions
- ☐ Skin rash Chronic/recurrent
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other_____

Immune Conditions
- ☐ AIDS or HIV infection
- ☐ Rheumatoid arthritis
- ☐ Immunosupression
  - ☐ Disease-induced _____
  - ☐ Drug-induced _____
  - ☐ Radiation induced _____
- ☐ Other_____

Other
- ☐ Domestic violence victim
- ☐ Glaucoma
- ☐ Organ/Tissue transplant
- ☐ Night sweats
- ☐ Unintended weight loss
- ☐ Chronic pain site

Additional Information on medical conditions

Care Providers

Do you have a primary care provider? __ Yes ___ No
Name of Primary physician:_____
Phone: _____

Have there been changes to your health the last 5 years?
- ☐ Illness _____
- ☐ Hospitalized _____

_____

Allergies

Are you allergic to any of the following: local anesthetic, Penicillin/antibiotics, Barbiturates, Sulfa drugs, Latex, Codeine or other narcotics, nickel? _____

Type of reaction_____

Other Allergies: _____

Yes	No	D/K	
			Has your physician recommended that you take antibiotics prior to dental treatment?
			Have you had an orthopedic total joint replacement? When? _____
			Do you have a heart murmur or a history of rheumatic heart disease?
			Have you taken biphosponates? How long?
			Have you taken cortisone (steroids) in the last 30 days?
			Do you use or have you used recreational (street) drugs? _____
			Have you received treatment for chemical or alcohol dependency? _____
			Have you used tobacco? Amount: _____ # years_____ Stopped?_____

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Drug	Dose/Day	Date Started	Reason

SURGERIES (Include all the surgeries that you have undergone)		
Surgery	Date	Comments

General Dental History

Are you receiving routine dental care? __ Yes ___ No
Name of Dentist:_____
Phone: _____

Last Dental Visit Reason and Date: _____
_____ Last Dental X-rays: _____

What brings you to the clinic today? _____
Any Dental Pain: _____

Past Dental Treatment

- ☐ Orthodontics (braces) _____
- ☐ Oral Surgery (extractions, etc) _____
- ☐ Periodontics (gum treatment) _____
- ☐ Endodontics (Root canal) _____
- ☐ Restorations (Fillings) _____
- ☐ Crowns and Bridges _____
- ☐ Partial Dentures _____
- ☐ Full Dentures _____
- ☐ Dental implants _____

Current Dental Concerns

Are you satisfied with the appearance of your smile/teeth? What would you like to change? _____

Are your teeth sensitive to hot, cold, sweet, pressure? _____

Do you have any swelling(s) in your mouth? _____

Are your teeth loose or shifting? _____

Have you felt any change of your bite? _____

Have you ever had problem/complications with past dental care? Please explain _____
_____
_____
_____

Is there any other dental concern that has not been discussed?
_____
_____
_____

Sleep Questionnaire

Please indicate if you experience or have experience any of these symptoms. Use the scale to measure the severity:
0 – No occurrence 1 – Occurs Rarely 2 – Occurs 2-4 times per week 3 – Occurs 5-7 times per week

__ Snoring
__ Interrupted snoring where breathing stops
__ Labored, difficult or loud breathing at Night
__ Gasping for air when sleeping
__ Mouth breathing while Awake
__ Mouth breathing while sleeping
__ Restless Sleep
__ Grinds teeth while sleeping
__ Talks in sleep
__ Excessive sweating while sleeping
__ Waking up at night
__ Using the restroom during the night
__Feels Sleepy and/or irritable during the day
__ Headaches

__ Frequent throat infections
__ Seasonal Allergies
__ Short attention span
__ Difficulty listening/ often interrupt
__ Hyperactive
__ ADD/ADHD
__ Sensory issues
__ Avoidance behavior toward food or certain types of food
__ Speech issues

Only Children and Adolescents
__ Wets the bed (currently)
__ History of bed Wetting
__ Ear infections or history of ear infections
__Struggles in math at school

__Struggles in reading at school
__ Speech issues
__ Difficult to understand speech
__ Difficult to understand over the phone
__ Nasal Speech
__ Hoarseness
__ Other have difficulty understanding speech
__ Gets frustrated when people can't understand
__ Speech sounds abnormal
__ Sometimes omits consonants
__ Uses M,N,NG instead of P,V,S,Z sounds
__ Drinking or solids get into nasal area when eating or drinking

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Oral Hygiene

Type of toothbrush that you use: __ Hard __ Med __ Soft __ Extra Soft __Electric. Brushing #times/day _____

Flossing # times/day: _____

Toothpaste type: __Fluoride __ Whitening __Tartar Control Other _____

Other fluoride ____ Rinse (OTC) ____ Prescription __ gel ___ Toothpaste __ tablets ____ Other

Mouth Rinse # times/day _____ Brand ? _____

Other Oral self-care _____

- ▫ Does your saliva feels thick or ropey?
- ▫ Does your mouth feels dry?
- ▫ Do you have excess saliva?
- ▫ Do you have difficulty chewing food?
- ▫ Do you have difficulty speaking?

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand that it is very important to report any changes or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Signature: _____ Date: _____

If other than the patient, indicate relationship: parent or legal guardian _____

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