PATIENT MEDICAL HISTORY

Robert R. Goldwin, D.D.S
Family Dentistry
Memphis, Tennessee

Date: _______________ Email Address: ______________________________

Name: ______________________________ Cell Phone: ________________ Dental Insurance:

Address: ____ 1. ____

City: ________________________________State: ______ Zip: ___________ 2. ____

Occupation: ____ Who will pay for this account? ______________________________

Employer: _____________________________ Work Phone: ______________ Referred by? ____

Work Address: ____ Physician Name: ____

Social Security Number: ____________________ Birth Date: ______________ Physician Phone No.: ____________________________________

Parent or Guardian (if under 18): _____________________________________ Reason for Dental Visit: __________________________________

Spouse: ____ ____

Spouse Employer: _______________________ Work Phone: ______________ Emergency Contact: ______________________________________

Social Security Number: ____________________ Birth Date: ______________ Emergency Contact Phone No. ____________________________

Do you have active tuberculosis? (Please circle your response): YES NO If yes, please return this form to the receptionist.

DENTAL INFORMATION

For the following questions, please circle YES or NO in response to the following questions:

Do your gums bleed when you brush or floss? YES NO
Are your teeth sensitive to hot, cold, sweets, or pressure? YES NO
Does food or floss catch between your teeth? YES NO
Is your mouth dry? YES NO
Have you had any periodontal (gum) treatments? YES NO
Have you had any problems associated with previous dental treatments? YES NO

Date of your last dental exam: _____________________________

Do you have any clicking, popping, or discomfort in the jaw? YES NO
Do you brux or grind your teeth? YES NO
Do you have sores or ulcers in your mouth? YES NO
Do you wear dentures or partials? YES NO
Do you participate in active recreational activities? YES NO
Have you ever had a serious injury to your head or mouth? YES NO
What was done at that time? ________________________________
____

Date of your last dental x-rays: ______________________________

What is the reason for your dental visit today? ____
____

How do you feel about your smile? ____

MEDICAL INFORMATION

For the following questions, please circle YES or NO in response to the following questions:

Are you now under the care of a physician? YES NO

Physician Name: _______________________Ph No.: _____________________
Address: ____
City: ______________________________ State: ________ Zip: _____________

Are you in good health? YES NO

Has there been any change in your general health within the past year? YES NO
If yes, what condition(s) is/are being treated? ____
____

Date of your last physical exam: ______________________________
Have you had a serious illness, operation, or been hospitalized in the past 5 years? YES NO
If yes, what was the illness or problem? ____
____

Are you taking or have you recently taken any prescription or over the counter medicines? Yes No
If yes, please list all, including any vitamins, natural or herbal preparations and//or diet supplements? ______________________________
____
____

PATIENT MEDICAL HISTORY (Continued)

Allergy Information: For the following questions, please circle YES or No if you are allergic to, or have had an allergic reaction, to any of the following. If you select yes, then please specify the type of reaction:

Allergy			Allergy		
Local Anesthetics ____________________________	YES	NO	Metals ____	YES	NO
Aspirin _____________________________________	YES	NO	Latex (rubber) __________________________________	YES	NO
Penicillin ___________________________________	YES	NO	Iodine ____	YES	NO
Other antibiotics ______________________________	YES	NO	Hayfever/Seasonal _______________________________	YES	NO
Barbiturates, sedatives, or sleeping pills ____________	YES	NO	Animals ____	YES	NO
Sulfa drugs __________________________________	YES	NO	Food ____	YES	NO
Codeine or other narcotics _____________________	YES	NO	Other ____	YES	NO

Disease/Problem Information: For the following questions, please circle YES or No if you have or have had any of the following.

Heart Murmur Yes No
Mitral valve prolapse Yes No
Artificial heart valve Yes No
Rheumatic fever Yes No
Cardiovascular disease Yes No
Angina Yes No
Arteriosclerosis Yes No
Congestive heart failure Yes No
Coronary artery disease Yes No
Damaged heart valve Yes No
Heart Attack Yes No
Low blood pressure Yes No
High blood pressure Yes No
Congenital heart defects Yes No
Pacemaker Yes No
Rheumatic heart disease Yes No
Abnormal bleeding Yes No
Anemia Yes No
Blood transfusion Yes No
If yes, date: _______________
Hemophilia Yes No
AIDS or HIV infection Yes No
Arthritis Yes No
Autoimmune disease Yes No

Rheumatoid arthritis Yes No
Systemic lupus erythematosus Yes No
Asthma Yes No
Emphysema Yes No
Sinus Trouble Yes No
Tuberculosis Yes No
Cancer/Chemotherapy/ Radiation Treatment Yes No
Chest pain upon exertion Yes No
Chronic Pain Yes No
Diabetes Type I or II Yes No
Eating disorder Yes No
Malnutrition Yes No
Gastrointestinal disease Yes No
G.E. Reflux/persistent heartburn Yes No
Ulcers Yes No
Thyroid problems Yes No
Stroke Yes No
Glaucoma Yes No
Hepatitis, jaundice or liver disease Yes No
Epilepsy Yes No

seizures

Fainting spells or Neurological disorders Yes No
If yes, specify: _____________
Sleep disorder Yes No
Mental Health disorder Yes No
If yes, specify: _____________
Recurrent infections Yes No
If yes, specify: _____________
Kidney problems Yes No
Night sweats Yes No
Osteoporosis Yes No
Persistent swollen glands in neck Yes No
Severe headaches/ Migraines Yes No
Severe or rapid weight loss Yes No
STD Yes No
Excessive urination Yes No

Have you had orthopedic total joint replacement (hip, knee, elbow, or finger)? Yes No

If yes, date: ________________________

Have you had complications? Yes No

Are you taking, or scheduled to being taking, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's Disease? Yes No

Have you been treated, or are you scheduled to receive treatment, with the intravenous bisphosphanates (Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's Disease, multiple myeloma, or metastic cancer? Yes No

Do you use controlled substances? Yes No

Do you use tobacco (smoking, snuff, chewing, bidis)? Yes No

If yes, how interested are you in quitting? (circle one) Very / Somewhat / Not Interested

Do you drink alcoholic beverages? Yes No

If yes, how much do you drink in a day? ______________________ in a week? _____________________________

Women only: Are you pregnant? Yes No

If yes, number of weeks? ______________________

Taking birth control pills or hormonal replacement? Yes No

Nursing? Yes No