PREHN DENTAL OFFICE
PATIENT MEDICAL HISTORY

PATIENT NAME:_____ DATE: _____

FAMILY PHYSICIAN:_____ ANY SPECIALIST?:_____
Do we have your permission to contact your personal physician if the need arises?
Yes_____No_____

Are you currently under a Medical Doctors care for a physical condition? Yes_____No_____
Please explain:_____
_____

Pharmacy:_____

List All Medications: Non-Prescription & Prescription

Allergies:

Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Metals
☐	☐	Codeine	☐	☐	Jewelry	☐	☐	Penicillin
☐	☐	Dental Anesthetics	☐	☐	Latex	☐	☐	Tetracycline

Other:_____
_____

Miscellaneous:

Y N
☐ ☐ Do You Smoke or Use Tobacco?

Height:_____'_____"___ Weight:_____

☐ ☐ Have you lost/gained more than 10 lbs. in the past year?

For Women Only:

Y N
☐ ☐ Are you taking birth control pills?
☐ ☐ Are you pregnant? # of weeks_____
☐ ☐ Are you nursing?

Office Use: BP_____/_____Heart Rate:_____

Conditions: Please check Yes or No to the Following

Y	N		Y	N		Y	N		Y	N		Y	N	
☐	☐	B/4 Dental Appts Do You Premedicate?	☐	☐	Abnormal Bleeding	☐	☐	Herpes (Any Kind)	☐	☐	Emphysema	☐	☐	Hay Fever
☐	☐	Heart Problems	☐	☐	Anemia/Blood Disease	☐	☐	Fever Blisters/ Cold Sores	☐	☐	Pneumocystitis	☐	☐	Sinus Problems
☐	☐	Heart Attack	☐	☐	High Blood Pressure	☐	☐	Shingles	☐	☐	Ulcers/Colitis	☐	☐	Frequent Headaches
☐	☐	Heart Murmur	☐	☐	Artificial Joint	☐	☐	Malignant Hyperthermia	☐	☐	Kidney Problems	☐	☐	Thyroid Problems
☐	☐	Chest Pain	☐	☐	Hepatitis A	☐	☐	High Cholesterol	☐	☐	Cancer	☐	☐	Sleep Apnea/ Excessive Snoring
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis B	☐	☐	Alcohol/Drug Abuse	☐	☐	Radiation/ Chemotherapy	☐	☐	TMJ/TMD Problems
☐	☐	Mitral Valve Prolapse	☐	☐	Hepatitis C	☐	☐	Psychiatric/ Emotional Care	☐	☐	Epilepsy/ Seizures	☐	☐	Arthritis/ Rheumatism
☐	☐	Rheumatic Fever	☐	☐	HIV+ AIDS	☐	☐	Respiratory Problems	☐	☐	Liver Disease	☐	☐	Venereal Disease
☐	☐	Hemophilia	☐	☐	Stroke	☐	☐	Asthma	☐	☐	Tonsils/ Adnoids Removed	☐	☐	Fainting/Dizzy Spells
☐	☐	Coumadin	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Eye/Ear Disorder	☐	☐	Do You Take Herbs/Vitamins?

I attest these answers to be truthful and as complete as possible.

Signature:_____Date:_____

PLEASE COMPLETE THE BACK OF THIS FORM

PREHN DENTAL OFFICE

DENTAL INFORMATION

NAME:_____ DATE:_____

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE NOW OR MAY HAVE HAD IN THE PAST:

Bleeding Gums
Swelling or Lumps in Mouth
Clenching or Grinding Teeth
Blisters/Sores on Lips or Mouth
Oral Habits, e.g. fingernail biting
Unfavorable Dental Experience
Extensive Crown and Bridge-work

Bad Breath
Periodontal Treatment
Orthodontic Treatment
Mouth Breathing
Complications from Oral Surgery
Pain or Unusual sounds in Jaw, Joints, or Ear

CIRCLE ANY OF THE FOLLOWING THAT YOU USE:

Cigarettes, pipe, cigars _____ per day
Chewing tobacco
Pop and/or Juice intake_____ per day

Dental Floss___ x/week
Water Jet Device
Fluoride Supplements or Rinse
Brush your teeth____x/day

Do you prefer anesthetics? No_____ Yes_____ Do you prefer Nitrous Oxide (laughing gas)? No_____ Yes_____

At present, do you have any dental concerns?_____
_____

Have you experienced trauma to the jaw? No_____ Yes_____
(Explain)_____

Have you had orthodontic treatment (braces)? No_____ Yes_____ Year_____

How long do you expect to keep your teeth? _____

What prompted you to seek dental care at this time?_____
_____

Is there anything in your past dental history I should know about? No_____ Yes_____(Explain)_____
_____

Are you satisfied with your past dental care?_____

Date of last teeth cleaning:_____ Date of last dental x-rays:_____

Do you like the way your teeth look when you smile? No_____ Yes_____

What would you change about your smile if you answered "No" to the above question?_____
_____

Are you interested in learning how to enhance your smile through shaping, veneers, bonding, bleaching, orthodontics?
No_____ Yes_____

Are you aware Prehn Dental Office offers an at-home bleaching system and how it can make a difference in your smile?
No_____ Yes_____

Have any teeth been injured due to accidents or falls?_____Explain:_____
_____