Neighborhood Smiles - Ryan Yakowicz, DDS
120 Greenway Cross Court, Belleville, WI 53508

PATIENT NAME: _____ BIRTH DATE: _____

MEDICAL HEALTH HISTORY

Do you have--or have you had--any of the following? (Please check all that apply)

- ☐ Abnormal bleeding after extractions, surgery or trauma
- ☐ AIDS or HIV positive
- ☐ Alcohol/drug dependency
- ☐ Allergies or hives
- ☐ Anemia or blood disorders
- ☐ Arthritis/rheumatism
- ☐ Artificial heart valve
- ☐ Artificial joint -Type: _____
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Bone disorders
- ☐ Cancer or tumor -Type: _____
- ☐ Chemotherapy
- ☐ Congenital heart problems
- ☐ Diabetes (insulin/diet controlled)
- ☐ Digestive disorders/acid reflux
- ☐ Emotional problems ☐ Anxiety ☐ Depression
- ☐ Epilepsy, seizures or fainting spells
- ☐ Glaucoma
- ☐ Hay fever or sinus trouble
- ☐ Head or neck injuries
- ☐ Hearing problems
- ☐ Heart ailment or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Heart pacemaker
- ☐ Hepatitis/jaundice/or other liver disease
- ☐ Herpes or cold sores
- ☐ High blood pressure ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Lung or breathing problems
- ☐ Migraine headaches or frequent headaches
- ☐ Multiple sclerosis
- ☐ Neurologic condition
- ☐ Neuromuscular disease
- ☐ Osteoporosis
- ☐ Psychiatric treatment
- ☐ Radiation therapy
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Sexually transmitted disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid or parathyroid problems
- ☐ Ulcers

Is premedication required for treatment? ☐ **Yes** ☐ **No**

Medication taken for premedication: _____

Are you allergic to--or have you reacted adversely to--any of the following?

- ☐ Antibiotics
- ☐ Aspirin or ibuprofen
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Codeine or other narcotics
- ☐ Latex materials
- ☐ Local anesthetics ("Novocain")
- ☐ Nut allergy
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Tetracycline
- ☐ Other: _____

Please list all medications you are taking: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you taking any of the following? (Check all that apply)

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (blood thinners)
- ☐ Antidepressants or tranquilizers
- ☐ Aspirin
- ☐ Cortisone or other steroids
- ☐ High blood pressure medicine
- ☐ Insulin or other diabetes drug
- ☐ Nitroglycerin
- ☐ Osteoporosis (bone density) medicine

Do you smoke or use chewing tobacco? ☐ **Yes** ☐ **No**

Women:

- ☐ May be pregnant
  Expected delivery date: _____
- ☐ Taking hormones or contraceptives

Name of your physician: _____
Do you have any disease or condition not listed above? _____
Have you been hospitalized in the last five years? Please explain: _____
_____
Please add anything else you would like us to know about: _____
_____

Reviewed: _____ **Date**: _____

Reviewed: _____ **Date**: _____

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DENTAL HISTORY

Last Dental Treatment_____ Last Dental X-rays_____
Previous Dentist_____ How long with this dentist_____
How often are your teeth cleaned?_____

Please answer by circling YES or NO to the following:

YES NO Is there anything you would like to change about the look or feel of your teeth?
YES NO Dental fears or unfavorable experiences?
YES NO Problems with effectiveness or bad reactions to dental anesthetics?
YES NO Orthodontic treatment? (Date_____)
YES NO Periodontal (gum) treatment?
YES NO Avoid brushing any part of your mouth?
YES NO Have gums that bleed when brushing or flossing?
YES NO Have teeth that are sensitive to hot or cold?
YES NO Have sore or painful teeth?
YES NO Have a burning sensation in your mouth?
YES NO Have difficulty swallowing?
YES NO Have an unpleasant taste or odor in your mouth?
YES NO Dry mouth, throat, and/or eyes?
YES NO Jaw problems (temporomandibular joint)?
YES NO Difficulty in opening your mouth widely?
YES NO Stiff neck muscles?
YES NO Awaken with an awareness of your teeth or jaw?
YES NO Have tension headaches?
YES NO Clench or grind your teeth?
YES NO Lost any teeth?
YES NO Wear a bite splint, night guard, orthodontic retainer, or sleep apnea appliance?
YES NO Sores or growths in your mouth?
YES NO Loose teeth or broken fillings?
YES NO Food collection between teeth?

How often do you brush?_____
How often do you floss?_____

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a removable partial or complete denture, please complete the following:

YES NO Has your present denture been relined? When?_____

YES NO Is your present denture a problem? Describe_____
_____
_____
_____

YES NO Are you satisfied with the appearance?

YES NO Are you satisfied with the comfort?

When did you receive your first partial or complete denture?_____

How long have you worn your present denture?_____

Patient Signature (parent/guardian)_____ **Date**_____
Doctor's Signature_____ **Date**_____
*Reviewed*_____ *Date*_____
*Reviewed*_____ *Date*_____