OVERLAND PARK DENTISTRY

South Overland Park: 913-647-8700 | Fax: 913-647-8701

Downtown Overland Park: 913-341-2380 | Fax: 913-341-2381

Sedalia, MO: 660-826-0448 | Fax: 660-826-0448

PATIENT MEDICAL & DENTAL HISTORY: (PLEASE PRINT)

PATIENT NAME: ____ DOB: ________ Est. Height: _____ Est. Weight: _____
FIRST MI LAST

PRIOR DENTIST: _________________ PHONE #:______________ PCP/CLINIC NAME: _____________ CLINIC PH #: ___________

		YES	NO
1.	Are you under medical treatment now? If yes, for what?		
2.	Are you wearing contacts?		
3.	Are you currently on blood thinners?		
4.	Do you use tobacco? (chew/smoke)		
5.	Do you use alcohol, cocaine, or other drugs? *(If yes, circle type)*		

		YES	NO
6.	Have you ever been hospitalized for any surgical operations or serious illness? If yes, for what?		
7.	WOMEN ONLY:		
	Are you pregnant or think you may be pregnant?		
	Are you nursing?		
	Are you taking birth control pills?		

Are you Allergic to or have you had any reactions to the following?

	YES	NO
Allergic to any Food Substances? (ex. Soy, Peanuts, Eggs) To What? - List		
Allergic to any Medications? (ex. Penicillin, Sulfa) To What? - List		

	YES	NO
Aspirin		
Barbiturates		
Codeine		
Iodine		

	YES	NO
Latex		
Local Anesthetics (ex., Novocaine)		
List-		

Other (list below):

Are you taking any medication(s) including non-prescription medicine/supplements? ☐ ***YES*** ☐ ***NO*** ***IF YES, PLEASE LIST BELOW:***

Name of Medicine/Supplement	Dosage/Frequency	Name of Medicine/Supplement	Dosage/Frequency

Do you have or have you had any of the following?

	YES	NO
Abnormal Bleeding		
Acid Reflux		
AIDS or HIV		
Anemia		
Angina		
Arthritis		
Artificial Heart Valve		
Asthma		
Bruise Easily		
Cancer		
Cardiac Pacemaker		
Chest Pains		
Congenital Heart Disorder		

	YES	NO
Dental Anxiety		
Diabetes		
Easily Winded		
Emphysema		
Epilepsy/Convulsions		
Excessive Bleeding		
Fainting/Seizures		
Frequently Tired		
Glaucoma		
Hay Fever/ Allergies		
Heart Attack		
Heart Disease		
Heart Murmur		

	YES	NO
Heart Trouble		
Hemophilia		
Hepatitis/ Jaundice		
High Blood Pressure		
Joint Replacement		
Kidney Diseases		
Leukemia		
Liver Disease		
Low Blood Pressure		
Mitral Valve Prolapse		
Radiation Therapy		
Respiratory Problems		
Rheumatic Fever		

	YES	NO
Scarlet Fever		
Sleep Apnea		
STD		
Stroke		
Swollen Ankles		
Thyroid Problem		
Tuberculosis		
Ulcers		
Unexplained Weight Loss		
Yellow Jaundice		
Other:		

How often do you Floss? __________ **Brush?** ___________ **Last Dental Cleaning:** ___________ **Last Dental X-rays:** ____________

		YES	NO
1.	Do your gums bleed while brushing or flossing?		
2.	Are your teeth sensitive to hot or cold liquids/foods?		
3.	Are your teeth sensitive to sweet or sour liquids/ foods?		
4.	Do you feel pain in any of your teeth?		
5.	Do you have any sores or lumps in or near your mouth?		
6.	Have you had gum treatments? (SRP, Deep Cleaning, Grafts?)		
7.	Have you ever experienced any of the following problems in your jaw?		
	Clicking or Popping?		
	Pain (joint, ear, side of face?)		
	Difficulty in opening or closing?		
	Difficulty in chewing?		
8.	Do you take Pre-meds for Dental Procedures? If yes, what kind?		

		YES	NO
9.	Have you had any head, neck or jaw injuries?		
10.	Do you have frequent headaches?		
11.	Do you clench or grind your teeth?		
12.	Do you bite your lips or cheeks frequently?		
13.	Have you ever had any difficult extractions in the past?		
14.	Have you ever had prolonged bleeding following extractions?		
15.	Have you ever had instruction on the correct method of brushing your teeth?		
16.	Have you ever had instructions on the care of your gums?		
17.	Have you had any orthodontic (braces) work?		
18.	Do you experience dry mouth?		
19.	Do you have difficulty getting numb?		
20.	Would you like to change anything about your smile?		

Patient Signature: ______________________________________ ***Date:*** __________ ***Date Re-Reviewed & No Changes:*** _____________