A.R. WYNNYKIW, DDS, PLLC
Progressive General & Cosmetic Dentistry

# Patient Medical & Dental Information

**Our Goal** is to get to know you as a whole person, and plan to do so through open and honest communication. Please fill out this form completely so that we can provide you with the best possible service.

**Today's Date** _____ **Patient Name** _____

**Do you have specific questions for the dentist?** Yes ☐ No ☐ **Why have you come to the dentist today?** _____

**What prescription or non-prescription medications are you currently taking?** Include herbal remedies and recreational drugs. _____

**Please check at least one box on each line below. There are no "correct" answers!**

1. My mouth is: ☐ very comfortable. ☐ moderately comfortable. ☐ uncomfortable.
2. My smile: ☐ is excellent. ☐ is not a concern to me. ☐ could be improved.
3. My dental health is: ☐ excellent. ☐ good. ☐ fair. ☐ poor.
4. Choose one: ☐ I will do whatever I must to keep my teeth. ☐ I want to keep my teeth but only within a certain budget of time and money.
5. Choose one: ☐ In the past, I've done the dentistry recommended to me. ☐ I've not done dentistry recommended to me. ☐ Never been recommended.

| | Yes | No |
|---|---|---|
| Are you currently in any pain? | ☐ | ☐ |
| Are you under a physician's care now? | ☐ | ☐ |
| Has your physician told you that you require antibiotics before dental treatment? | ☐ | ☐ |
| Have you been hospitalized or have you had a serious illness in the last three years? | ☐ | ☐ |
| Have you gained or lost 10+ pounds in the past year? | ☐ | ☐ |
| Do you wear contact lenses? | ☐ | ☐ |
| Do you have frequent sore throats? | ☐ | ☐ |
| Do you get/have enlarged lymph nodes/glands? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Do you get/have enlarged lymph nodes/glands? | ☐ | ☐ |
| Do you have any sexually transmitted infections? | ☐ | ☐ |
| Have you tested positive for HIV/AIDS? | ☐ | ☐ |
| Do you have any history of cancer? | ☐ | ☐ |
| Have you undergone radiation therapy? | ☐ | ☐ |
| Have you undergone chemotherapy? | ☐ | ☐ |

If yes to any of the above items, please list/explain:

## Allergies >> Are you allergic to or have you reacted adversely to any of the following?

| | Yes | No |
|---|---|---|
| Aspirin | ☐ | ☐ |
| Codeine | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Local anesthetic* | ☐ | ☐ |
| Penicillin | ☐ | ☐ |
| Other Antibiotics* | ☐ | ☐ |
| Latex | ☐ | ☐ |
| Sulfa | ☐ | ☐ |
| Nickel / other metal* | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Iodine | ☐ | ☐ |
| Nitrous Oxide | ☐ | ☐ |
| Milk/Casein | ☐ | ☐ |
| Chlorine/Clorox | ☐ | ☐ |
| Are you aware of being allergic to any other medications or substances?* | ☐ | ☐ |
| Do you have any food allergies?* | ☐ | ☐ |

*If yes to any of the above items, please list/explain:

## Cardiovascular >> Past or Present

| | Yes | No |
|---|---|---|
| Congestive Heart Failure | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Chest Pain/Angina | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Rheumatic Fever | ☐ | ☐ |
| Congenital Heart Defect | ☐ | ☐ |
| Prosthetic Heart Valve | ☐ | ☐ |
| Arrhythmias | ☐ | ☐ |
| Pacemaker or Defibrillator | ☐ | ☐ |
| Coronary Bypass | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Coronary Transplant | ☐ | ☐ |
| Aneurysm | ☐ | ☐ |
| Other Heart Condition (Describe): | ☐ | ☐ |

**CONTINUE ON REVERSE >>**

## Dermal/Musculoskeletal >> Past or Present

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Skin Rash | ☐ | ☐ | Connective Tissue Disorders | ☐ | ☐ |
| Night Sweats | ☐ | ☐ | Systemic Lupis | ☐ | ☐ |
| Osteoarthritis | ☐ | ☐ | Congenital Anomaly/ Genetic Syndromes | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ | Have you taken or do you currently take bisphosphonates | | |
| Artificial/Prosthetic Joint | ☐ | ☐ | (i.e. Fosamax, Boniva)? | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ | If so, for how long? | | |

## Endocrine >> Past or Present

| | Yes | No |
|---|---|---|
| Diabetes Type 1 | ☐ | ☐ |
| Diabetes Type 2 | ☐ | ☐ |
| Have you used/do you use Cortisone or other steroids? | ☐ | ☐ |

## Genitourinary >> Past or Present

| | Yes | No |
|---|---|---|
| Frequent Urination | ☐ | ☐ |
| Kidney Problem | ☐ | ☐ |
| Bladder Problem | ☐ | ☐ |
| Dialysis | ☐ | ☐ |

## Neurologic >> Past or Present

| | Yes | No |
|---|---|---|
| Vision Problems | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Earaches/Tinnitus/Ear Ringing | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Severe Headaches/Migraines Frequency: | ☐ | ☐ |
| Mild/Moderate Headaches Frequency: | ☐ | ☐ |
| Fainting or Dizzy Spells | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Anxiety/Nervousness | ☐ | ☐ |
| Panic Attacks | ☐ | ☐ |
| Phobias | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Convulsions | ☐ | ☐ |
| Psychiatric treatment | ☐ | ☐ |

## Sleep >> Past or Present

| | Yes | No |
|---|---|---|
| Apnea | ☐ | ☐ |
| Do you use 2 or more pillows? | ☐ | ☐ |

## Gastrointestinal >> Past or Present

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| GERD/Reflux | ☐ | ☐ | Cirrhosis | ☐ | ☐ |
| Stomach/Intestinal Ulcers | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Colitis | ☐ | ☐ | Eating Disorder | ☐ | ☐ |
| Persistent Diarrhea | ☐ | ☐ | Anorexia | ☐ | ☐ |
| Hepatitis A | ☐ | ☐ | Bulemia | ☐ | ☐ |
| Hepatitis B | ☐ | ☐ | Malabsorption | ☐ | ☐ |
| Hepatitis C | ☐ | ☐ | Celiac Disease | ☐ | ☐ |
| Jaundice | ☐ | ☐ | Gluten Sensitivity | ☐ | ☐ |

## Hematologic >> Past or Present

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Blood Transfusion | ☐ | ☐ | Leukemia | ☐ | ☐ |
| Anemia | ☐ | ☐ | Sickle Cell Anemia | ☐ | ☐ |
| Hemophelia | ☐ | ☐ | Excessive/Irregular Bleeding | ☐ | ☐ |

## Pulmonary >> Past or Present

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Hay Fever | ☐ | ☐ | Emphysema | ☐ | ☐ |
| Seasonal Allergies | ☐ | ☐ | Chronic Bronchitis | ☐ | ☐ |
| Sinus Trouble | ☐ | ☐ | COPD | ☐ | ☐ |
| Asthma | ☐ | ☐ | Tuberculosis (TB) | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ | Breathing Difficulties | ☐ | ☐ |

## Substances >>

| Do you use: | Now | Past | Never | List frequency and duration for each: |
|---|---|---|---|---|
| Tobacco/Cigarettes? | ☐ | ☐ | ☐ | |
| Chewing Tobacco? | ☐ | ☐ | ☐ | |
| Alcohol? | ☐ | ☐ | ☐ | |
| Recreational Drugs? | ☐ | ☐ | ☐ | |
| Intravenous Drugs? | ☐ | ☐ | ☐ | |
| Fen Phen? | ☐ | ☐ | ☐ | |

## Women >>

Are you pregnant or possibly pregnant? Yes ☐ No ☐
Are you using birth control pills? Yes ☐ No ☐
Are you nursing? Yes ☐ No ☐ If so, for how long? _____

## Other >> Past or Present

Disease/Problem/Condition Not Listed: _____

Is there any other medical or dental information that you feel your dentist should know about? ☐ Yes ☐ No If yes, please describe: _____

## Patient or Parent/Guardian

**I attest that the answers I have provided in this questionaire are true and accurate to the best of my knowledge.**

**Name** _____ **Signature** _____ **Date** _____