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. _____

Pharmacy Name, Location, & Telephone: _____

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 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 Lupus	☐	☐
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	☐	☐
Hemophilia	☐	☐	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** _____