MEDICAL HISTORY

Patient Name_____

Name of Physician/Specialty_____Reason for Treatment_____

Date of most recent physical examination _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE OR HAVE YOU EVER HAD:

	Yes	No		Yes	No		Yes	No
Hospitalization for illness or injury	☐	☐	Kidney disease	☐	☐	Neurologic Problems	☐	☐
Heart problem	☐	☐	Liver disease	☐	☐	Viral infections and cold sores	☐	☐
Heart murmur	☐	☐	Jaundice	☐	☐	Any lumps/swelling in the mouth	☐	☐
Rheumatic Fever	☐	☐	Thyroid or Parathyroid disease	☐	☐	Hives, skin rash, hay fever	☐	☐
Scarlet Fever	☐	☐	Hormone deficiency	☐	☐	Venereal disease	☐	☐
High blood pressure	☐	☐	High Cholesterol	☐	☐	Hepatitis (type_____)	☐	☐
Low blood pressure	☐	☐	Diabetes	☐	☐	HIV/AIDS	☐	☐
A stroke	☐	☐	Stomach or duodenal ulcer	☐	☐	Tumor/abnormal growth	☐	☐
Artificial prosthesis (i.e. heart valve or joints)	☐	☐	Digestive disorders	☐	☐	Radiation therapy	☐	☐
Anemia or other blood disease	☐	☐	Osteoporosis/Osteopenia	☐	☐	Chemotherapy	☐	☐
Prolonged bleeding due to a slight cut	☐	☐	Arthritis	☐	☐	Emotional Problems	☐	☐
Emphysema	☐	☐	Glaucoma	☐	☐	Psychiatric treatment	☐	☐
Tuberculosis	☐	☐	Contact Lenses	☐	☐	Antidepressant medication	☐	☐
Asthma	☐	☐	Head or neck injuries	☐	☐	Alcohol/drug dependency	☐	☐
Breathing/Sleep problems (i.e. snoring, sinus)	☐	☐	Epilepsy/Convulsions (seizures)	☐	☐	Malignant Hyperthermia	☐	☐

ARE YOU:

	Yes	No		Yes	No
Presently being treated for any other illness	☐	☐	A smoker or smoked previously	☐	☐
Aware of a change in your general weight	☐	☐	Often unhappy or depressed	☐	☐
Taking medication for weight management	☐	☐	Often exhausted or fatigued	☐	☐
Taking dietary supplements	☐	☐	Subject to frequent headaches	☐	☐
FEMALE - pregnant	☐	☐	MALE – prostate disorders	☐	☐
FEMALE – taking birth control pills	☐	☐			

ALLERGIC REACTION TO:

	Yes	No
Penicillin	☐	☐
Erythromycin	☐	☐
Tetracycline	☐	☐
Codeine	☐	☐
Local Anesthetic	☐	☐
Fluoride	☐	☐
Acetaminophen	☐	☐
Latex	☐	☐
Aspirin	☐	☐
Metals (type_____)	☐	☐
Ibuprofen	☐	☐
Any other medication _____	☐	☐

G.A.S.P. Questionnaire

	Yes	No	Not Sure
Have you been told (or noticed on your own)that you snore on most nights?	☐	☐	☐
Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?	☐	☐	☐
Are you tired, fatigued or sleepy on most days?	☐	☐	☐
Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?	☐	☐	☐
Are you overweight?	☐	☐	☐

☐ Yes Total +	☐ Not sure Total =	☐	0	1	2	3	4	5
			Low Risk		Medium Risk		High Risk	

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

List any medications, supplements and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Signature/Guardian_____ Date_____

DENTAL HISTORY

Patient Name_____SSN_____

Address_____City, St, Zip _____

DOB_____ Phone_____ Emergency Contact_____

What would you like your smile to look like in 20 years? _____
How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____ How did you hear about us? _____
Date of most recent dental exam and x-rays _____
Date of most recent treatment (other than a cleaning) _____
I routinely see my dentist every: ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY	Yes	No
Are you fearful of dental treatment? Scale of 1 to 10 (very)	☐	☐
Have you had an unfavorable dental experience?	☐	☐
Have you ever had complications from past dental treatment?	☐	☐
Have you ever had trouble getting numb or reactions to local anesthetic?	☐	☐
Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
Have you had any teeth removed?	☐	☐

SMILE CHARACTERISTICS		
Is there anything about the appearance of your teeth that you would like to change?	☐	☐
Have you ever whitened (bleached) your teeth?	☐	☐
Are you self conscious about your teeth?	☐	☐
Have you been disappointed with the appearance of previous dental work?	☐	☐

BITE AND JAW JOINT		
Do you/ would you have any problems chewing gum?	☐	☐
Have your teeth changed in the last 5 years, become shorter, thinner, worn?	☐	☐
Are your teeth crowding or developing spaces?	☐	☐
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐	☐
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
Do you have tension headaches or sore teeth?	☐	☐

TOOTH STRUCTURE		
Have you had any cavities within the past 3 years?	☐	☐
Do you have a dry mouth?	☐	☐
Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
Have you ever had a toothache, cracked filling, or broken, chipped or cracked tooth?	☐	☐
Do you feel or notice any holes (i.e. pitting) in your teeth?	☐	☐

GUM AND BONE		
Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
Have you ever experienced gum recession?	☐	☐
Do your gums bleed when brushing, flossing or eating?	☐	☐
Are your teeth becoming loose?	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐

Signature _____ Date _____

Relationship to patient _____

WOODLAND DENTISTRY

1301 HAWTHORNE ST.

Alexandria, MN 56308

WoodlandDentistryAlex@gmail.com

320-762-0279

320-219-7125 (fax)

REQUEST RELEASE OF INFORMATION

Date:

Patient _____ (Signature)

I, _____ give authorization to the

office of _____ to release dental records and radiographs to Woodland Dentistry, Dr.s Tyler Geyen, DDS and Elliot Larson, DDS
Family Members:

Name: DOB:

_____

_____

_____