ANAMOSA
900 E 3RD ST STE A
ANAMOSA, IA 52205
☎ 319-462-2313

JONES COUNTY
FAMILY DENTISTRY

MONTICELLO
139 S MAIN ST STE A
MONTICELLO, IA 52310
☎ 319-465-3233

Patient Name:_____

Date of Birth:_____

Medical History

General medical information

□ **Yes** □ **No** Have you been hospitalized, had any surgical operations or been seriously ill in the last 5 years?

If yes, please explain _____

Medical doctor's name and contact information _____

Date of your last physical _____

□ **Yes** □ **No** Do you have any artificial joints, heart valves, implants, or prosthesis

If yes, please specify procedure and date of surgery _____

□ **Yes** □ **No** Have you ever been told you need to be pre-medicated prior to dental treatment?

If yes, please specify _____

□ **Yes** □ **No** Have you ever had surgery, radiation therapy, or chemotherapy to treat a tumor, growth or other condition

If yes, please specify _____

□ **Yes** □ **No** Have you ever taken Fosamax, Boniva, Actonel, Reclast or any bisphosphonate medication used to treat osteoporosis and similar disease?

Women only

□ **Yes** □ **No** Are you pregnant?

If yes, when is your due date?_____

□ **Yes** □ **No** Are you breast feeding?

Are you taking any of the following? □ **Birth Control** □ **Fertility Drugs** □ **Hormone Replacement**

Allergies

Please indicate if you are allergic to or if you have any reactions to the following:

□ Local anesthetics-Novocain □ Penicillin/Amoxicillin □ Other antibiotics □ Sulfa Drugs □ Sedatives □ Aspirin □ Iodine

□ Codeine or other narcotics

Please list any other allergies _____

Medications

Please list any medications, including non-prescription medications, vitamins and supplements. Please provide a printed list if possible.

Medical Conditions

Please indicate if you have or have had any of the following

Heart/Circulatory problems

□ Heart attack □ High blood pressure □ Congenital heart defect/disease □ Coronary heart disease □ Arrhythmia

□ Infective endocarditis □ Chest pain (Angina) □ Heart murmurs □ Artificial valves

□ Other, please specify_____

Autoimmune problems

□ Diabetes □ Rheumatoid arthritis □ Multiple sclerosis □ Thyroid problems

□ Other, please specify_____

Breathing/lung problems

□ Asthma □ Emphysema □ Obstructive sleep apnea □ Positive test/treatment for tuberculosis

Have you had any of the following treatment for sleep apnea? □ CPAP/BiPAP □ Surgical correction □ Oral appliance

□ Other, please specify_____

Eye/ear/nose/throat problems

□ Vision problems □ Vertigo □ Hearing impairment □ Other, please specify_____

Liver problems

□ Hepatitis A, B or C □ Alcohol liver disease □ High cholesterol □ Other, please specify_____

Neurological problems

□ Stroke or transient ischemic attack □ Seizure/epilepsy □ Dementia/Alzheimer's □ Neuropathies (tingling, numbness)

□ Other, please specify_____

Mental health problems

□ Depression □ Anxiety □ Bipolar disorder □ Other, please specify_____

Blood problems

□ Anemia □ Bleeding disorder □ Other, please specify_____

Infectious disease problems

□ HIV/AIDS □ Sexually transmitted disease □ Cold sores □ Other, please specify_____

Stomach problems

□ GERD (Heart burn) □ Other, please specify_____

Muscle/bone problems

Please specify _____

Skin problems

Please specify _____

Dental History

□ **Yes** □ **No** Are you in pain?

If so, for how long? _____

Previous dentist's name and contact information _____

When was your last dental exam? _____

When were your last dental x-rays? _____

How many times a day do you brush your teeth? _____

How many times per week do you floss? _____

Do you have or have experienced any of the following?

□ Red, swollen or bleeding gums □ Lost or broken fillings □ Teeth sensitive to hot, cold or sweets

□ Teeth sensitive to biting or chewing □ Sores or lumps in or near mouth □ Teeth grinding/clenching □ Head, neck or jaw injuries

□ Ringing in ears □ Bad breath □ Discomfort, clicking or popping in jaw □ Broken or chipped teeth

□ Recent infections or sore throat □ Broken or chipped teeth □ Recent infections or sore throat □ Difficult tooth extractions

□ Prolonged bleeding after tooth extractions □ Tooth ache □ Orthodontic treatment □ A removable dental appliance

Do you have any specific problems you would like addressed? _____

How would you rate your smile? 1=worst, 4=best _____