RICK L. GRANT, DMD, INC.

FAMILY DENTISTRY, ORTHODONTIC, IMPLANTS

Medical History

Dental History

Do you have a specific dental problem? Describe _____ Yes No

Do you have dental exams on a routine basis? Last Visit _____ Yes No

Do you think you have active decay or gum disease? _____ Yes No

Do you brush or floss on a routine basis? Discuss _____ Yes No

Do your gums ever bleed? Discuss _____ Yes No

Do you like your smile? Why? _____ Yes No

Does food catch between your teeth? Any loose teeth? _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No

Do you smoke or chew? Any sores or growths in your mouth? Discuss? _____ Yes No

Sleep/Airway Issues

Does the patient tend to be a mouth breather? YES NO

Does the patient snore at night? YES NO

Does the patient seem rested in the morning? YES NO

Is the patient often sleepy during the day? YES NO

Has the patient seen an ENT specialist? YES NO

Is the patient using a sleep apnea device? YES NO

Medical History

Are you under a physician's care now? _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications: aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No

Are you on a special diet? Discuss _____ Yes No

Are you allergic to any medications or substances? Please check box below

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local anesthetics

☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

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***Do you now have or have you ever had any of the following?**

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Blood Disease/Bruise Easily
- ☐ Blood Transfusion
- ☐ Bloody Sputum
- ☐ Breathing Problems/Easily Winded
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Drug Addiction/Alcoholism
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur or Defect
- ☐ Heart Diseases/Surgery
- ☐ Heart Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Yellow Jaundice

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

To the best of my knowledge, all preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____ Date: _____