Ferguson Family Dentistry

8670 Ferry St, Montague, MI 49437 · (231) 894-4820

Patient Name: _____ **Date of Birth:** _____

Pharmacy Name: _____ Phone Number: _____

Physician's name? _____

Have you ever been told you need to Antibiotic Premedicate prior to dental appointment? ○ Yes ○ No If yes _____

Have you been hospitalized or had a major operation in the last 5 years? ○ Yes ○ No If yes _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes _____

Are you taking any medications Rx or over the counter? ○ Yes ○ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No If yes _____

Do you take blood thinners? ○ Yes ○ No If yes _____

Are you on a special diet? ○ Yes ○ No If yes _____

Do you use tobacco? ○ Yes ○ No If yes _____

Do you use controlled substances? ○ Yes ○ No If yes _____

Women: Are you… ○ Pregnant/Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following? ○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex

○ Sulfa Drugs ○ Local Anesthetics ○ Other ○ None _____

Do you have or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Easily Winded ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Emphysema ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Rheumatism ○ Yes ○ No
Anemia ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Angina ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Shingles ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Joint Replacement ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Glaucoma ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Hay Fever ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Ulcers ○ Yes ○ No
Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No

Any other health concerns or issues not listed? _____

NEW PATIENTS DENTAL HISTORY

Previous Dentist _____

Date of last dental exam: _____ Date of last dental x-rays _____

Has the patient had any injuries to the face, mouth, or teeth? ○ Yes ○ No
Describe _____

Do your gums bleed when you brush or floss? ○ Yes ○ No

Are your teeth sensitive to cold, hot, sweets, or pressure? ○ Yes ○ No

Does food or floss catch between your teeth? ○ Yes ○ No

Is your mouth dry? ○ Yes ○ No

Have you ever had perio (gum) treatments? ○ Yes ○ No

Have you ever had ortho (braces) treatments? ○ Yes ○ No

Have you had problems associated with previous dental treatments? ○ Yes ○ No

Is your home water fluoridated? ○ Yes ○ No

Are you currently experiencing dental pain or discomfort? ○ Yes ○ No

Do you have clicking, popping or discomfort in the jaw? ○ Yes ○ No

Do you clench or grind your teeth? ○ Yes ○ No

Do you have sores or ulcers in your mouth? ○ Yes ○ No

Do you wear dentures or partials? ○ Yes ○ No

Reviewed:

_____ Initial/Date _____ Initial/Date _____ Initial/Date _____ Initial/Date _____ Initial/Date