ROBERT M. KELSO D.D.S., P.C.
Family And Cosmetic Dentistry

MEDICAL HISTORY
(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Dr. ❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Birth date: / /

Are you currently under the care of a Physician? ❑ Yes ❑ No	Physician's Name:	Physician's Phone#:

1. Has there been any change in your general health in the last year? ❑ Yes ❑ No
2. Please list major surgeries that you have had in the past _____
3. Have you ever had any prolonged bleeding from a cut, injury, or tooth extraction? ❑ Yes ❑ No
4. Have you had any unusual reaction to local anesthetics? ❑ Yes ❑ No
5. Have you ever taken, or been prescribed, one of the following drugs for osteoporosis or cancer treatment (a bisphosphonate)? (Fosamax, Didronel, Aredia, Actonel, Skelid, Bondronat, Zometa, or Bonefos) ❑ Yes ❑ No
6. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No
7. *Women Only:* Are you pregnant or possibly pregnant? ❑ Yes ❑ No
   Are you nursing? ❑ Yes ❑ No
   Are you taking birth control pills or hormones? ❑ Yes ❑ No
8. Do you smoke or use tobacco in any form? ❑ Yes ❑ No
9. Do you use any controlled substances (i.e. marijuana or other drugs)? ❑ Yes ❑ No
10. Do you drink alcoholic beverages? If so, how many drinks per week? _____ ❑ Yes ❑ No
11. Is there any other disease, condition, or problem not listed? ❑ Yes ❑ No

MEDICATION

Please list all medications you are currently taking, including herbal remedies:

_____
_____
_____
_____

Please list all medications or drugs that you are allergic to:

_____
_____

CARDIAC CONDITIONS

Artificial (prosthetic) heart valve? ❑ Yes ❑ No

Damaged valves in transplanted heart? ❑ Yes ❑ No

Previous infective endocarditis? ❑ Yes ❑ No

Congenital heart disease? ❑ Yes ❑ No

Name of Cardiologist_____

HISTORY

Please indicate if you have, or have had in the past, any of the following medical conditions:

Anaphylaxis ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Artificial Joints ❑ Yes ❑ No
  Which joint? _____ When Replaced? _____
  Name of Orthopedic Surgeon _____
Asthma ❑ Yes ❑ No
Allergies or Hives ❑ Yes ❑ No
Cancer ❑ Yes ❑ No
Chemotherapy ❑ Yes ❑ No
Cosmetic Surgery of the head or neck ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Drug Dependancy ❑ Yes ❑ No
Epilepsy/Seizures ❑ Yes ❑ No
Glaucoma ❑ Yes ❑ No
Heart Disease ❑ Yes ❑ No
Heart Murmur ❑ Yes ❑ No
Heart Surgery ❑ Yes ❑ No
Hemophilia ❑ Yes ❑ No
Hepatitis ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No
AIDS ❑ Yes ❑ No
HIV Positive ❑ Yes ❑ No
Kidney Disease ❑ Yes ❑ No
Latex Allergy ❑ Yes ❑ No
Mitral Valve Prolapse ❑ Yes ❑ No
Respiratory Disease ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient or Responsible Party Signature: _____ Date: _____

Sign on back

OFFICE USE ONLY: _____
_____
_____

DENTAL HISTORY

Please indicate if you have, or have had in the past, any of the following dental conditions:

Do your gums bleed when you brush or floss?.. ❑ Yes ❑ No
How often do you brush? _____
How often do you floss? _____
Use WaterPik or floss aids? ..... ❑ Yes ❑ No
Do you have a problem with bad breath?..... ❑ Yes ❑ No
Do you have any loose teeth? ..... ❑ Yes ❑ No
Are your teeth sensitive to cold, hot, sweets or pressure? ..... ❑ Yes ❑ No
Does food or floss catch between your teeth? .. ❑ Yes ❑ No
Do you have headaches, earaches, facial pain, or neck pains?..... ❑ Yes ❑ No
Do you have any clicking, popping or discomfort in the jaw? ..... ❑ Yes ❑ No
Do you brux or grind your teeth?..... ❑ Yes ❑ No
Have you worn a mouth guard or splint before? ❑ Yes ❑ No
Is your mouth dry?..... ❑ Yes ❑ No
Do you have sores or ulcers in your mouth?..... ❑ Yes ❑ No
Have you had any periodontal (gum) treatments or surgeries?..... ❑ Yes ❑ No
Name of periodontist _____.

Have you had any oral surgery or dental implants placed? ..... ❑ Yes ❑ No
Name of oral surgeon _____.
Do you wear dentures or partials? ..... ❑ Yes ❑ No
Have you ever had orthodontic (braces) treatment?.. ❑ Yes ❑ No
Do you participate in active recreational activities? ... ❑ Yes ❑ No
Have you ever had a serious injury to your head or mouth? ..... ❑ Yes ❑ No
Have you had any problems associated with previous dental work?..... ❑ Yes ❑ No
Are you currently experiencing dental pain or discomfort?..... ❑ Yes ❑ No
Are you apprehensive about dental treatment? ❑ Yes ❑ No

If the patient is a child, please check any of the following habits the child has:

❑ Thumbsucking ❑ Mouthbreathing
❑ Nailbiting ❑ Unusual Speech Patterns

Date of your last dental exam: _____

What treatment was done at that time? _____

Date of last dental x-rays: _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Is there anything you would like to change about your smile? _____

_____

_____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient or Responsible Party Signature: _____ Date: _____

OFFICE USE ONLY: _____

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