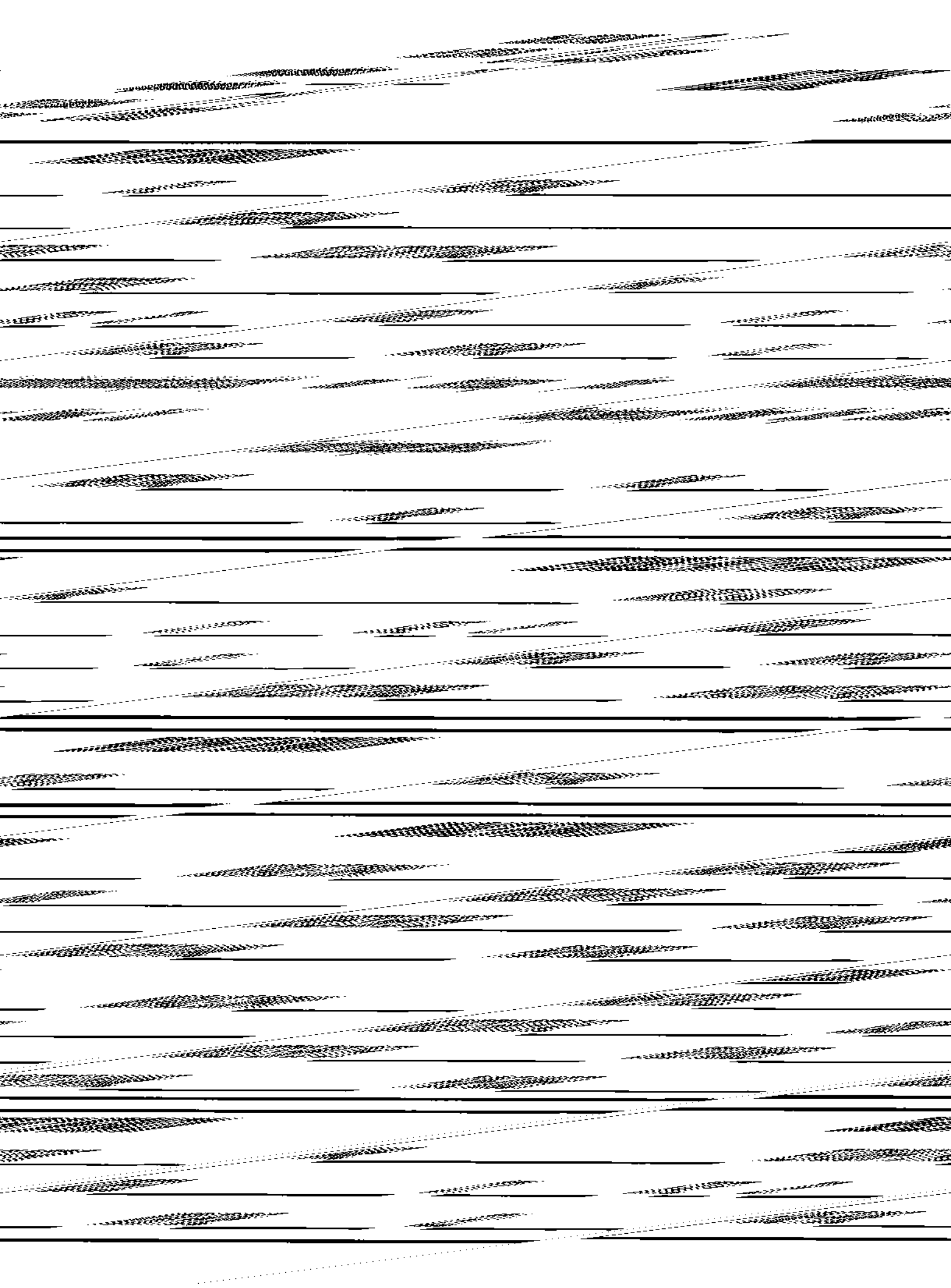

Dr. Loper Dentist

MEDICAL - DENTAL HISTORY

PATIENT NAME:_____

DATE OF BIRTH:_____

Office: 303.794.3965
Fax: 303.794.4784
www.drloperdentist.com
info@drloperdentist.com
1279 W. Littleton Blvd
Littleton, CO 80120

PATIENT MEDICAL HISTORY

Name of Physician:_____

Date of last physical:_____ Phone:_____

Pharmacy Name:_____

Pharmacy Phone:_____

☐YES ☐NO Are you under any medical treatment now?
If so, please list:_____

☐YES ☐NO Have you had any surgeries?
If so, please list:_____

☐YES ☐NO Have you had any recent joint replacements?

☐YES ☐NO Have you been told you need to pre-med?

☐YES ☐NO Ever had a serious accident involving head or jaw injuries?

Have you ever had any of the following?

☐ Heart Ailment	☐ Tumors or Growths
☐ Heart Murmur	☐ Any Blood Disease
☐ Mitral Valve Prolapse	☐ Any Liver Disease
☐ High Blood Pressure	☐ Any Kidney Disease
☐ Low Blood Pressure	☐ Any Stomach or Intestinal Disease
☐ Respiratory Disease	☐ Any Venereal Disease
☐ Diabetes	☐ Yellow Jaundice or Hepatitis
☐ Rheumatic Fever	☐ Epilepsy
☐ Arthritis	☐ AIDS
☐ Multiple Sclerosis	☐ Other:_____

☐YES ☐NO Are you allergic to any known materials or medications resulting in hives, asthma, eczema, etc?
(Please list)_____

☐YES ☐NO Do you have a latex allergy?

☐YES ☐NO Do you have any reason to suspect you are ***not*** in good health?

☐YES ☐NO Have any wounds healed slowly or presented other complications?

☐YES ☐NO Are you pregnant? If so, when is your due date?_____

☐YES ☐NO Have you ever had Chemotherapy/Radiation?
When?, Where? _____

☐YES ☐NO Have you ever had any head and neck Radiation Treatment?

☐YES ☐NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker? _____

☐YES ☐NO Are you currently using tobacco products?

☐YES ☐NO Are you now taking prescription drugs, medications or blood thinners?

☐YES ☐NO Are you taking bisphosphonate drugs?(i.e. Fosamax, Zometa,Actenol)

☐YES ☐NO Are you currently taking any Immune Suppressant Drugs?

Please list all current medication including over the counter.

Current Medication	Reason

PATIENT DENTAL HISTORY

Date of last dental visit:_____

When was your last Full Mouth Series of x-rays taken?
When?_____Where?_____

☐YES ☐NO Do you have any specific problems?

☐YES ☐NO Do you have pain in or near your ears?

☐YES ☐NO Any unhealed injuries or inflamed area in or around your mouth?

☐YES ☐NO Have you experienced any growth or sore spots in your mouth?

☐YES ☐NO Any reactions or allergic symptoms to local anesthetic?

☐YES ☐NO Any difficult extractions in the past?

☐YES ☐NO Have you had prolonged bleeding following extractions in the past?

☐YES ☐NO Do your gums bleed?

☐YES ☐NO Have you been instructed on the correct method of brushing your teeth and flossing your teeth?

☐YES ☐NO Have you ever been told you have gum disease?

☐YES ☐NO Do you habitually clench your teeth during the day or night?

☐YES ☐NO Any part of your mouth sore to pressures or irritants (cold, hot, pressure, sweets, etc)
If so, where?_____

Signature:_____

Date:_____

Date	Change	Signature
1.		
2.		
3.		