coulter
FAMILY DENTISTRY

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Dental Information

How would you rate the condition of your mouth? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Previous Dentist Name and Phone Number: _____

Date of most recent dental exam and dental x-rays: _____

I routinely see my dentist every: ❒ 3 mo ❒ 4 mo ❒ 6 mo ❒ 12 mo ❒ not routinely

What is your immediate concern? _____

Is there anything about the appearance of you smile that you would like to change? _____

Check all that apply:

❒ Had complications from past dental treatment

❒ Had trouble getting numb

❒ Had any reactions to local anesthetic

❒ Had/have braces, orthodontic treatment

❒ You experience dry mouth

❒ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth

❒ Food gets trapped between any teeth

❒ Have you ever whitened or bleached your teeth

❒ Have you experienced popping and/or clicking of your jaw joint

❒ You have difficulty chewing

❒ You clench or grind your teeth

❒ You wear or have worn a bite appliance

❒ Gums bleed when brushing or flossing

❒ Treated for gum disease or were told you have lost bone around your teeth

❒ Noticed an unpleasant taste or odor in your mouth

❒ Experienced gum recession

❒ Had any teeth become loose on their own (without injury)

❒ Experienced a burning sensation in your mouth

❒ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe: _____

Name: _____

Health History

What is your estimate of your general health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Are you under the care of a physician or medical specialist? ❒ Yes ❒ No

If yes: What is your physician's name? _____ Phone #: _____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

Preferred Pharmacy and location: _____

*Do you take an Antibiotic Pre-Med before dental treatment? ❒ Yes ❒ No

If yes please explain: _____

ALLERGIES: all to be answered as yes or no, If yes what was the reaction? _____

❒ Yes ❒ No	Local anesthetics	❒ Yes ❒ No	Erythromycin	❒ Yes ❒ No	Latex
❒ Yes ❒ No	Aspirin	❒ Yes ❒ No	Keflex	❒ Yes ❒ No	Hay Fever
❒ Yes ❒ No	Codeine	❒ Yes ❒ No	Sulfa	❒ Yes ❒ No	Metals
❒ Yes ❒ No	Penicillin	❒ Yes ❒ No	Sulfite		
❒ Yes ❒ No	Azithromycin			Other: _____	

MEDICATIONS

Please list all medications (prescription and non-prescription) AND the reason for taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Updated by: Dr. _____ Date: _____

Updated by: Dr. _____ Date: _____

Updated by: Dr. _____ Date _____

Name: _____

Systems Review

Indicate which of the following conditions you have or have had.

HEART *(Cardiovascular System):* to be answered as yes or no

❒ Yes ❒ No Hypertension *(High Blood Pressure)*

❒ Yes ❒ No Hypotension *(Low Blood Pressure)*

❒ Yes ❒ No Heart Valve Replacement *(Artificial Heart Valve)*

❒ Yes ❒ No Myocardial Infarction *(Heart Attack)* If yes when was the last heart attack? _____

❒ Yes ❒ No Angina *(Heart Pain)*

❒ Yes ❒ No Dysrhythmia *(Irregular Heart Beat)*

❒ Yes ❒ No Murmur

❒ Yes ❒ No Congestive Heart Failure

❒ Yes ❒ No Coronary Heart Disease

❒ Yes ❒ No Dyspnea upon Exertion *(Difficulty breathing upon exertion)*

❒ Yes ❒ No Mitral Valve Prolapse

❒ Yes ❒ No Coronary Stent(s)

❒ Yes ❒ No Congenital Heart Disorder

❒ Yes ❒ No History of Infective Endocarditis

❒ Yes ❒ No Pacemaker

Other _____

BRAIN *(Central Nervous System):* to be answered as yes or no

❒ Yes ❒ No Seizures/Epilepsy

❒ Yes ❒ No Cerebral Vascular Attack *(Stroke)* If yes when was your last stroke? _____

❒ Yes ❒ No Transient Ischemic Attack *(Mini Stroke)*

❒ Yes ❒ No Paralysis (Loss of muscle function)

❒ Yes ❒ No Meningitis *(Inflammation around the brain)*

❒ Yes ❒ No Encephalitis *(Inflammation of the brain)*

❒ Yes ❒ No Head Aches

❒ Yes ❒ No Memory Loss

❒ Yes ❒ No Fainting

❒ Yes ❒ No Multiple Sclerosis

❒ Yes ❒ No Numbness

❒ Yes ❒ No Weakness

❒ Yes ❒ No Trigeminal Neuralgia

❒ Yes ❒ No Glaucoma

Other _____

LUNGS *(Pulmonary System):* to be answered as yes or no

❒ Yes ❒ No Asthma

❒ Yes ❒ No Chronic Obstructive Pulmonary Disease

❒ Yes ❒ No Bronchitis

❒ Yes ❒ No Pneumonia

❒ Yes ❒ No Sleep Apnea

❒ Yes ❒ No Snore

❒ Yes ❒ No Tuberculosis

❒ Yes ❒ No Persistent Cough

Other _____

Name: _____

KIDNEYS *(Renal System):* to be answered as yes or no

❒ Yes ❒ No Acute Kidney Failure *(sudden kidney failure)*

❒ Yes ❒ No Chronic Kidney Failure *(kidney failure over time)*

❒ Yes ❒ No Kidney Stones

❒ Yes ❒ No On Dialysis

Other _____

HORMONES *(Endocrine System):* to be answered as yes or no

❒ Yes ❒ No Diabetes, if yes Type I or Type II? _____

❒ Yes ❒ No Hypothyroidism *(underactive thyroid)*

❒ Yes ❒ No Hyperthyroidism *(overactive thyroid)*

❒ Yes ❒ No Hashimoto's

❒ Yes ❒ No Graves Disease

❒ Yes ❒ No Steroid Use

❒ Yes ❒ No Obesity

Other _____

BONES, MUSCLES, JOINTS *(Musculoskeletal System):* to be answered as yes or no

❒ Yes ❒ No Osteoporosis ❒ Yes ❒ No Bone Fracture

❒ Yes ❒ No Malignant Hyperthermia *(severe reaction to certain anesthetic)*

❒ Yes ❒ No Arthritis ❒ Yes ❒ No Cervical Spine Injury

❒ Yes ❒ No Head or Neck Injury ❒ Yes ❒ No Joint Replacement

❒ Yes ❒ No Rheumatism ❒ Yes ❒ No Sinus Trouble

Other _____

BLOOD *(Hematologic System):* to be answered as yes or no

❒ Yes ❒ No Bruises Easy ❒ Yes ❒ No Anemia *(lack of normal number of blood cells)*

❒ Yes ❒ No Sickle Cell Anemia ❒ Yes ❒ No Coagulopathy *(excessive bleeding or clotting)*

❒ Yes ❒ No Blood Transfusion, If yes what was the date of known transfusion? _____

❒ Yes ❒ No Hemophilia ❒ Yes ❒ No Blood Disease

Other _____

LIVER *(Hepatic System):* to be answered as yes or no

❒ Yes ❒ No Hepatitis, If yes what type? _____

❒ Yes ❒ No Cirrhosis of the Liver ❒ Yes ❒ No Jaundice

Other _____

Name: _____

DIGESTIVE *(Gastrointestinal System):* to be answered as yes or no

❒ Yes ❒ No Hiatal Hernia
❒ Yes ❒ No Reflux/GERD
❒ Yes ❒ No Constipation
❒ Yes ❒ No Irritable Bowel Syndrome *(IBS)*
❒ Yes ❒ No Eating Disorder
❒ Yes ❒ No Peptic Ulcer Disease
❒ Yes ❒ No Gastroparesis
❒ Yes ❒ No Clostridium difficile *(C-diff)*
❒ Yes ❒ No Colitis

Other _____

REPRODUCTIVE *(Gynecologic System):* to be answered as yes or no

❒ Yes ❒ No History of Infection while pregnant
❒ Yes ❒ No Currently Pregnant, If yes how far along? _____
❒ Yes ❒ No Currently Nursing

Other _____

CANCER *(Oncology):* to be answered as yes or no first, If yes then answer the following

❒ Yes ❒ No Cancer Type: _____ Date of Diagnosis: _____

Treatment Regimen: _____

Radiation: _____

Recurrence: ❒ Yes ❒ No Currently in Remission: ❒ Yes ❒ No

PSYCHIATRIC/PSYCHOLOGIC: to be answered as yes or no

❒ Yes ❒ No Anxiety
❒ Yes ❒ No Depression

Other _____

HABITS: to be answered as yes or no

❒ Yes ❒ No Tobacco: Type, amount, and for how long? _____

❒ Yes ❒ No Vaping: Type, amount, and how often? _____

❒ Yes ❒ No Marijuana/CBD
❒ Yes ❒ No Non-Prescribed non OTC drugs
❒ Yes ❒ No Recreational Drug Use
❒ Yes ❒ No Alcohol, if yes how often?
❒ Yes ❒ No Chemical Dependency

Other _____

Name: _____

DEVELOPMENTAL CHALLENGES: to be answered as yes or no

❒ Yes ❒ No Down Syndrome: Trisomy 21
❒ Yes ❒ No Trisomy 18
❒ Yes ❒ No Trisomy 16
❒ Yes ❒ No Trisomy 13
❒ Yes ❒ No Spectrum Disorder/Autistic
❒ Yes ❒ No Cerebral Palsy
❒ Yes ❒ No ADD/ADHD

Other _____

INFECTIOUS DISEASES: to be answered as yes or no

❒ Yes ❒ No HIV/AIDS
❒ Yes ❒ No Hepatitis
❒ Yes ❒ No Herpes
❒ Yes ❒ No Scarlet Fever
❒ Yes ❒ No Rheumatic Fever

AUTOIMMUNE DISORDERS: to be answered as yes or no

❒ Yes ❒ No Sjogren's Syndrome
❒ Yes ❒ No Fibromyalgia

Other _____

GENERAL: to be answered as yes or no

❒ Yes ❒ No Recent fever/chills
❒ Yes ❒ No Recent weight loss

ALL PEDIATRIC PATIENT'S

How much does your child weight in lbs? _____

❒ Yes ❒ No Are there any special concerns? _____

INTERESTED IN SEDATION? ❒ Yes ❒ No

(if yes please answer the following questions)

❒ Yes ❒ No Any Chance of Pregnancy?

How much do you weigh in lbs? _____

❒ Yes ❒ No Have you been sedated or undergone anesthesia before?

❒ Yes ❒ No If yes, did you experience any complications? _____
❒ Yes ❒ No Are you aware of any family members who experienced complications with sedation/anesthesia?
❒ Yes ❒ No Do you wear contact lenses?

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change I will inform the doctor at my next appointment.

Signature or Authorized Witness _____ Date _____

Reviewed by: Dr. _____ Date _____