Fred T. Ridge, D.D.S
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Medical History Form

Patient's Name: ______________________________ Date: ____________________

Birth Date: ________________ Sex: M F Height: ________ Weight: ___________

For the following questions, circle yes or no. Whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health?.......... Yes No
2. Has there been any change in your health in the past year?.......... Yes No
3. My last physical exam was on ____________________
4. Are you now under the care of a physician? .... Yes No
   If so, for what condition? .... Yes No
5. The name / address / phone number of my physician is: ____________________________________

   ____

6. Have you had any serious illness, operation or hospitalization with the past 5 years?.......... Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.) .... Yes No
   Name of premedication: ______________________
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)?..........Yes No
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies?Yes No If so, please list: ____

   ____

   ____

   (If you have a list, we will copy)

10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur..........Yes No
    b. Rheumatic Heart Disease .... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition .... Yes No

1. Do you experience any chest pain? .... Yes No
2. Shortness of breath after mild exercise?.......... Yes No
3. Do your ankles swell?.......... Yes No

    d. Allergies.......... Yes No
    e. Sinus trouble .... Yes No
    f. Asthma or hay fever? Where was your last ER visit for asthma? ______________ .... Yes No
    g. Fainting spells or seizures. When was your last seizure? ________________ .... Yes No
    h. Diabetes: do you take injections or pills to manage?.......... Yes No
    i. Hepatitis, jaundice or liver disease.......... Yes No
    j. Frequent or recurring mouth sores.......... Yes No
    k. Thyroid problems.......... Yes No
    l. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) .... Yes No
    n. Do you have high cholesterol?.......... Yes No
    o. Stomach ulcer or hyperacidity.......... Yes No
    p. Kidney trouble .... Yes No
    q. Tuberculosis.......... Yes No
    r. Persistent cough or cough that produces blood.......... Yes No
    s. Persistent swollen neck glands .... Yes No
    t. Low blood pressure.......... Yes No
    u. Epilepsy or neurological disorder including depression, anxiety, panic disorder .... Yes No
    v. Cancer.......... Yes No
    w. Any disease drug or transplant operation that has depressed your immune system .... Yes No

11. Have you had abnormal bleeding? .... Yes No
   a. Have you ever required a blood transfusion? If so, what year? __________ .... Yes No
12. Do you have any blood disorder such as anemia? .... Yes No
13. Have you ever had treatment for a tumor or growth? .... Yes No
14. Have you had radiation therapy to the head, neck or jaws? .... Yes No
15. Have you had any serious trouble associated with previous dental treatment .... Yes No
    If so explain: ____________________
16. Do you have any other condition or disease you think the doctor should know about? .... Yes No
    If so, explain: ____________________
17. Do you smoke or chew tobacco? .... Yes No If so how much? __________
18. Is there any past history of alcohol or chemical dependency or emotional disorder
    that may affect the care we provide you? .... Yes No
19. Are you wearing contact lenses? .... Yes No
20. Are you wearing removable dental appliances? .... Yes No
21. Do you wish to talk with the doctor privately about anything? .... Yes No
22. Have you ever been diagnosed with sleep apnea? .... Yes No
    If yes do you wear a CPAP or Appliance? ____________________

WOMEN

23. Are you pregnant or trying to become pregnant .... Yes No
24. Are you nursing? .... Yes No
25. Are you taking birth control pills? .... Yes No

Chief Dental Complaint:

____

____

____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: __________ Patient/Parent/Guardian Signature: __________

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: __________

Significant findings from questionnaire or oral interview: __________

Dental management considerations: __________

Date: __________ Doctor's Signature: __________

Medical History Update:

Date __________ Comments __________ Signature __________

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DENTAL HISTORY

Date of Last Dental Visit__________________Last Dental Cleaning______________Last Full Mouth X-rays_______________

What was done at your last dental visit?____

____

Previous Dentist's Name____

Address____State______________Zip______________________

Telephone____

How often do you have dental examinations?____

How often do you brush your teeth?___________________________How often do you floss?____________________________

What other dental aids do you use? (Interplak, toothpick, etc.)____

Do you have any dental problems now? Yes No

If yes, please describe____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any bad odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other lesions?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If yes, please describe, including cause
____

Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where?____________________

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Do you:			Are you satisfied with your teeth's appearance?	Yes	No
Clench or grind your teeth while awake or asleep?	Yes	No	Would you like to keep all of your teeth all of your life?	Yes	No
Bite your lips or cheeks regularly?	Yes	No	Do you feel nervous about having dental treatment? If so, what is your biggest concern?________________________ ____	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, nails, fingernails)	Yes	No	Have you ever had an upsetting dental experience? If yes, please describe____________________________________ ____	Yes	No
Mouth breathe while awake or asleep?	Yes	No			
Have tired jaws, especially in the morning?	Yes	No			
Smoke / chew tobacco?	Yes	No			