MOUNTAIN SHADOWS FAMILY DENTAL

21765 W. Yuma Rd Ste. 101
Buckeye, AZ 85326
623-691-6300

YOUR NAME: _____ TODAYS DATE: _____

PHYSICIAN NAME: _____ PHONE #: _____

When was your last visit to your physician? _____ When was your last complete physical? _____

MEDICAL HISTORY

PLEASE TELL US IF YOU HAVE HAD ANY OF THE FOLLOWING BY CHECKING THE APPROPRIATE CIRCLE.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Angina chest pain
- ☐ Any artificial replacement/ Artificial Knee
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Blood disease
- ☐ Cancer/Tumor/Growth
- ☐ Chemical dependency
- ☐ Congenital heart lesion
- ☐ Congestive heart failure
- ☐ Diabetes
- ☐ Dialysis
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Eye Disorders or Glaucoma
- ☐ Fever Blisters
- ☐ Hay Fever
- ☐ Heart attack _____ year
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Immunosuppressive disorders/ARC
- ☐ Irregular Heart Beat
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Low Blood Pressure
- ☐ Malignancies
- ☐ Mitral valve prolapse
- ☐ Neurological problem
- ☐ Psychiatric problems
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Heart Disease
- ☐ Rheumatic Heart Fever
- ☐ Rheumatism/Arthritis
- ☐ Shortness of breath
- ☐ Sickle Cell Anemia
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Ulcers/Colitis
- ☐ Venereal disease
- ☐ OTHER: Please List _____ _____

*__Please__ list all **Medications** that you are currently taking **(Include the dosage and frequency that you are on):**

_____

ALLERGIES (Please select all that apply)

- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Bactrim
- ☐ Cipro
- ☐ Codeine
- ☐ Doxycycline
- ☐ Erythro
- ☐ Iodine
- ☐ Latex
- ☐ Opiates
- ☐ Other _____
- ☐ Penicillin
- ☐ Septra
- ☐ Sulfa
- ☐ Tetracycline

*FOR WOMEN ONLY

Are you taking Birth Control? Yes☐ No☐ Are you Pregnant? Yes☐ No☐ If Yes, What is your Due Date? ____/_____/_____

DENTAL HISTORY

Please describe your chief oral complaint:

_____

Are your teeth sensitive to:	YES	NO
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Chewing?	☐	☐
Do you have any food traps?	☐	☐
Do your gums ever feel tender or swollen?	☐	☐
Do your gums bleed when brushing?	☐	☐
Do you have any teeth that feel loose?	☐	☐
Have you ever been treated for Periodontal Disease?	☐	☐
Do you use dental floss?	☐	☐

	YES	NO
Have you had any previous injuries to your face or jaw?	☐	☐
Do you lose or break fillings?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you seem to strike some teeth before others when chewing?	☐	☐
Have you ever had your bite adjusted?	☐	☐
Do your jaws ever feel tired or ache?	☐	☐
Can you chew comfortably of both sides on your mouth?	☐	☐
Have you had a complete dental examination?	☐	☐
Including full mouth x-rays in the past 3 years?	☐	☐
Have you had your teeth cleaned regularly?	☐	☐
Do you have all or most of your natural teeth?	☐	☐

	YES	NO
Would you like to keep your natural teeth?	☐	☐
If you've had teeth removed, have they been replaced?	☐	☐
Do you like the appearance of your smile?	☐	☐

	YES	NO
Do you consider yourself a nervous dental patient?	☐	☐
Have you ever had an unpleasant dental experience?	☐	☐
Have you ever experienced problems with Novocain?	☐	☐

When was your last dental appointment? _____

What was done at that visit? _____

When was your last cleaning? _____

Where was it done? _____

If you could improve your teeth or smile, what would you do? _____

Consent: To the best of my knowledge, the above information on this Health History sheet is as complete and as accurate as possible. I understand that without full and accurate information, the Doctor may not be able to provide me with the best care possible. I hereby authorize the Doctor to take radiographs (x-rays), study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. Also, by presenting myself for treatment, I authorize the Doctor to perform any and all treatment, medication, and therapy which may be indicated and I further authorize and consent that the Doctor use such assistance as he/she deems fit.

Signature of Patient/Guardian _____ Date: _____/_____/_____

Print Name if different from Patient _____