LOWRY DENTISTRY

210 S. Willow Street • Gastonia, NC 28054

Date _____

Name _____ DOB _____
first middle last

Dental History

Are you in good health?	Y	N	Have you received dental care in the past 12 months?	Y	N
Do your gums bleed?	Y	N	Do you have unusual or frequent pain with any of the following:		
Do you have hot/cold sensitivity?	Y	N	teeth	Y	N
Frequent headaches?	Y	N	jaw joints	Y	N
Any unusual swelling in your mouth?	Y	N	jaws	Y	N
Do you smoke or vape?	Y	N	Are you frightened of dental treatment?	Y	N
Date of last dental exam _____			Previous dentist _____		
Do you have sleep apnea and/or use a c-pap?	Y	N	Are you aware of clinching or grinding your teeth?	Y	N

Reason for coming? _____

Medical History

Under a physician's care? Y N If yes, please explain _____

Name of family physician _____ Date of last physical _____

Please list any medications you are presently taking : _____

Please list any allergies (ex. Medications, latex, etc.]) : _____

If you are female, are you pregnant or trying to get pregnant? If yes, please indicate how far along and if you're having any complications?

Y N _____

Are you taking any bisphosphonates (ex. Fosamax, Boniva, Actonel, Reclast, Zometa, Aredia)? Y N If yes, please list:

_____

Are you taking any blood thinners? (ex.Warafin/Coumadin, Plavix, Asprin) Y N If yes, please list : _____

Please list any surgeries (ex. Heart bypass, joint replacements, transplants, etc.) and when : _____

_____

Do you have or have you had in the past any of the following? Please check all that apply:

Y	N	AIDS/HIV	Y	N	High blood pressure
Y	N	Acid Reflux/GERD/Frequent Heartburn	Y	N	History of Drug Dependency
Y	N	Anemia	Y	N	Renal Dialysis
Y	N	Angina/Chest pains	Y	N	Rheumatic Fever
Y	N	Arrhythmia/Irregular heart beat	Y	N	Kidney/Liver problems
Y	N	Artificial Heart Valve	Y	N	Mitral Valve Prolapse
Y	N	Asthma/Hay fever	Y	N	Night sweats
Y	N	Breathing problems, please specify	Y	N	Osteoarthritis
Y	N	Bleeding disorder/Bruise easily/trouble clotting	Y	N	Osteoporosis
Y	N	Cancer? What kind? When? _____	Y	N	Pacemaker
Y	N	Cold sores/Fever blisters	Y	N	Persistent cough
Y	N	Diabetes	Y	N	Glaucoma
Y	N	Epilepsy/Seizures/Convulsions	Y	N	Rheumatism/Rheumatoid factor
Y	N	Heart murmur	Y	N	Stroke
Y	N	Hepatitis (A, B, or C)	Y	N	Thyroid Disease
Y	N	Hemophilia	Y	N	Tuberculosis
			Y	N	Weight loss

Please list any other medical issues important to your care not listed above : _____

_____

I understand that the doctor is not responsible for completion of treatment if I fail to make scheduled appointments. I hereby certify that I have read the above information and that it is accurate to the best of my knowledge. The above information is confidential and will be used for my dental treatment. I understand that not providing accurate information could be detrimental to my health.

Signature of Patient or Authorized Person: _____ Date: _____