

Swiss Biologic Dentistry

Medical and Dental History

Patient Name: _____ Date of Birth: _____

Physician name: _____ Phone: _____

Date of last physical exam: _____ Are you currently under the care of a physician? _____

If yes, please explain: _____

Have you had or do you currently have any of the following conditions?

- | | | | | | |
|-------------------------|--|--|--|---|--|
| Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Acid Reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Appetite | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>Regurgitation</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina Pectoris | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headache | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia/ Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in jaw Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pulmonary Shunts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Bones | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Physiological <input type="checkbox"/> Functional <input type="checkbox"/> Innocent | | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bacterial Endocarditic | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | | Tobacco Use | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Chewing <input type="checkbox"/> Smoking | |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Colitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Defect | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Are you allergic to any of the following medications?

- | | | | | | |
|--------------------|--|--------------|--|--------|--|
| Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nitrous Oxide | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clindamycin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dental Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Valium | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metals | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ | | | |

List any medicines you are currently taking: _____

Are you currently taking bisphosphates **OR** have you taken any in the past like Reclast, Boniva, Actonel, Fosamax etc.: Yes No

Are you currently pregnant or trying to get pregnant? Yes No

Is there any other medical information not included above which you feel we should be informed about? Yes No

If yes, please explain: _____

What prompted you to seek dental care at this time? _____

How long has it been since your last thorough dental examination? _____

When were your teeth last cleaned? _____ X-rayed? _____

Have you had any previous periodontal therapy? If yes, please list the provider and dates: _____

Have you had any bad experiences in a dental office? _____

If yes, please explain: _____

Are you troubled with bad breath? Yes No

Do your gums bleed easily, feel tender or irritated? Yes No

Are there areas in your mouth where food sticks or get caught? Yes No

Are you self-conscious about the appearance of your teeth? Yes No

If yes, please explain: _____

Do your jaws feel tired or sore? Yes No

Do you experience excessive headaches and/or pain in the neck, shoulders or back? Yes No

Do you experience clicking or popping noises when opening or closing your mouth, or when chewing? Yes No

Are you aware of grinding or clenching your teeth? Yes No

Do you use any tobacco products? Yes No

Do you snore or experience breathing difficulties at night? Yes No

Do you currently wear any type of oral appliance? Yes No

Do you experience day-time fatigue? Yes No

Do you wake up one or more times during the night? Yes No

What, if anything, would you do to change the appearance of your teeth? _____

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize Swiss Biologic Dentistry and/or their trained staff to take X-rays, study models, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Swiss Biologic Dentistry and/or their trained staff to present my treatments needed according to their findings. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

Signature of Patient/Parent or Guardian

Date

Reviewed By

Date