

Ann G. Borgström DDS, PC
Whole Health Dentistry

Form 2: Medical and Dental History

Patient name	
Date of last physical exam	Blood pressure, if known
Physician name and phone	
Has your general health changed in the past year? If yes, please explain.	
Have you had any illness, accident or surgery in the past year? If yes, when? Please describe.	
Are you being treated by a physician for any reason at this time? If yes, whom?	
Please list any medications you are taking, including dosages.	
Have you ever been treated for osteoporosis? If yes, was any of the following prescribed? <input type="checkbox"/> Actonel	
<input type="checkbox"/> Aredia	<input type="checkbox"/> Boniva
<input type="checkbox"/> Fosamax	<input type="checkbox"/> Zometa
<input type="checkbox"/> Bonifos	<input type="checkbox"/> Skelid
<input type="checkbox"/> Ostac	<input type="checkbox"/> Didronel
Do you use tobacco in any form? How much and how often?	
Are you exposed to secondhand smoke?	
Do you drink alcohol? How much and how often?	
Women: Are you pregnant?	If yes, due date

Are you allergic or have you reacted adversely to any of the following?				
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Dental Local Anesthetics	<input type="checkbox"/> Metals	
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Other

Are you currently experiencing, or have you ever experienced, any of the following?			
<input type="checkbox"/> Heart trouble (including murmurs, valve prosthesis)		<input type="checkbox"/> High or low blood pressure	
<input type="checkbox"/> Venereal disease		<input type="checkbox"/> AIDS	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Hepatitis (or ever been tested for)		<input type="checkbox"/> Jaundice	<input type="checkbox"/> Eye or sinus problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies or Hay fever	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Tumors or growths	<input type="checkbox"/> Severe infections	<input type="checkbox"/> Fainting
<input type="checkbox"/> Headaches	<input type="checkbox"/> Back or shoulder pain	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Kidney problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Prolonged bleeding	<input type="checkbox"/> Anemia	<input type="checkbox"/> Other	

Are you currently undergoing, or have you ever undergone, the following treatments?			
<input type="checkbox"/> Aspirin therapy	<input type="checkbox"/> Birth control	<input type="checkbox"/> Radiation therapy	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Prosthetic joint surgery		<input type="checkbox"/> Hormone replacement therapy	<input type="checkbox"/> Other

Continued on back

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Form 2: Medical and Dental History Continued

Name of previous dentist		
How long?	Date of most recent dental exam	
Date of most recent dental treatment	Date of most recent dental x-ray	
How often do you have your teeth cleaned?	<input type="checkbox"/> Every 3 months	<input type="checkbox"/> Every 4 months
	<input type="checkbox"/> Every 6 months	<input type="checkbox"/> Once a year or less
Have you had orthodontic treatment? When?		
Have you had periodontal (gum) treatment? When?		
What is/are your immediate dental concern(s)?		
Have you ever been concerned about or sought treatment for the following? If yes, please explain.		
Appearance of your teeth		
Unfavorable dental experiences		
Fears of dental procedures		
Problems with effectiveness or bad reaction to dental anesthetic		
Bleeding gums		
Difficulty brushing any part of your mouth		
Part of your mouth sensitive to temperature		
Sore teeth		
Burning sensation in your mouth		
Difficulty swallowing		
Unpleasant taste or odor in your mouth		
Dry mouth, throat or eyes		
Jaw problems (temporomandibular joint)		
Difficulty opening your mouth wide		
Stiff neck muscles		
Awareness of your teeth or jaw upon awakening		
Tension headaches		
Clenching or grinding your teeth		
Clicking or popping jaw		
Difficulty chewing bagels		
Difficulty chewing gum		
Changes in the wear on your front teeth in the last 5 years		
Difficulty sleeping		
Teeth don't fit together easily when you bite down		
Sweating or trembling during examination		
Fear of new people or places		
If wearing a partial or complete denture:		
When did you receive your first denture?	How long have you worn your present denture?	
Has your present denture been relined? When?		
Are you satisfied with the appearance of your denture? Comfort? Chewing ability? Please explain.		

Patient signature	Date
Reviewing doctor	