Parkway Dental Care

Dr. Philip T. Philip

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YOUR NAME: _____ Today's Date: _____

Physician's Name: _____ Physician's 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 box(es):

- ☐ Bacterial Endocarditis
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Rheumatic Heart Fever
- ☐ Rheumatic Heart Disease
- ☐ Artificial Heart Valve(s)
- ☐ Congenital Heart Lesion
- ☐ Mitral Valve Prolapse
- ☐ Heart Attack _____Year
- ☐ Angina/Chest Pain
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Congestive Heart Failure
- ☐ Hemophilia
- ☐ Blood Disease
- ☐ Sickle Cell Anemia
- ☐ Anemia / Blood Problems
- ☐ Excessive Bleeding
- ☐ Asthma
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Eye Disorders / Glaucoma
- ☐ AIDS
- ☐ Immunosuppressive Disorders / ARC
- ☐ Any artificial replacement Artificial Knee, Hip, Joint Pins, Plate
- ☐ Rheumatism / Arthritis
- ☐ Neurological Problems
- ☐ Epilepsy / Seizures
- ☐ Psychiatric Problems
- ☐ Emotional Problems
- ☐ Alcoholism
- ☐ Chemical Dependency
- ☐ Drug Addiction
- ☐ Malignancies
- ☐ Cancers, Tumors, Growths
- ☐ Radiation Treatments
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Dialysis
- ☐ Liver Problems
- ☐ Hepatitis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcer / Colitis
- ☐ Venereal Disease
- ☐ Herpes
- ☐ Fever Blisters
- ☐ Pregnant _____ Months
- ☐ Oral Contraceptives

Please list any ALLERGIES to Drugs, Medications or Anesthetics: _____

_____

Please list any other MEDICAL CONDITIONS not mentioned above: _____

_____

Please list all DRUGS/MEDICATIONS you currently take: _____
(Include the dose and frequency that you are on) _____

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?	☐	☐
Have you had any previous injuries to your face or jaws?	☐	☐
Do you lose or break fillings?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you snore or have you been told that you snore?	☐	☐
Do you own a CPAP and how often do you wear it?	☐	☐
Do you strike some teeth before others when closing?	☐	☐
Have you ever had your bite adjusted?	☐	☐
Do your jaws ever ache or feel tired?	☐	☐

Have you had a complete dental examination,	Yes	No
Including full mouth X-rays in the last 3 years?	☐	☐
Have you had your teeth cleaned regularly?	☐	☐
When was your last cleaning? _____		
Do you have all or most of your natural teeth?	☐	☐
Would you like to keep your natural teeth?	☐	☐
If you had teeth removed, were they replaced?	☐	☐
Do you like the appearance of your smile?	☐	☐
If you could improve your teeth or smile, what would you do?		
_____		
Do you consider yourself a nervous patient?	☐	☐
Ever had an unpleasant dental experience?	☐	☐
When was your last dental appointment? _____		
What was done at that visit? _____		
_____		
Where was it done? _____		
Ever experienced problems with Novocain?	☐	☐