Brandon J. Hissong, DMD
Complete Family Dentistry

MEDICAL HISTORY

Name_____ Date of Birth_____ BP_____/_____

Physician(s)_____ Location_____ Date of Last Exam_____

Are you more than 10% above ideal body weight OR is your waist above 35" for women or 40" for male? □ Yes □ No

	Yes	No		Yes	No
Are you currently undergoing medical treatment.	☐	☐	Do you snore loudly (loud enough to be heard through closed doors)	☐	☐
Have you been hospitalized for any surgical operation or illness within the last 5 years? If yes, briefly explain below.	☐	☐	Do you wake up feeling tired or feel fatigued, tired, or sleepy during the day (fall asleep while driving or during conversations with others)	☐	☐
Are you taking any prescription medication? If yes, please list below.	☐	☐	Has anyone observed you choking/gasping during your sleep?	☐	☐
Are you taking any over-the-counter medications, vitamins, or supplements? If yes, please list below.	☐	☐	Neck Circumference_____ (office to measure is necessary)		
Have you taken Fosamax, Actonel, Boniva, or any other bisphosphonate for the treatment of cancer, osteoporosis, or osteopenia?	☐	☐	Women only:		
Are your currently using tobacco products? (Including vaping/e-cig) Type_____ How much per day_____	☐	☐	Are you pregnant or think you might be pregnant?	☐	☐
Have you used tobacco products in the past?	☐	☐	Are you nursing?	☐	☐
Do you use recreational drugs? If yes, explain_____	☐	☐	Are you taking oral contraceptives?	☐	☐
Have you had any joint replacements? If yes, when_____	☐	☐			

Are you allergic to or have you had any reactions to the following: ☐ Penicillin ☐Codeine/Narcotics ☐Local Anesthetic ☐Other_____

Do you have or have you have any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Stroke			Diabetes		
Low Blood Pressure			Fainting			Kidney Disease		
High Cholesterol			Epilepsy/Convulsions			Liver Disease		
Irregular Heart Beat			Multiple Sclerosis			Rheumatoid Arthritis		
Heart Disease			Fibromyalgia			Thyroid Problems		
Heart Attack			Anemia			Glaucoma		
Angina/Chest Pains			Leukemia			Asthma		
Swollen Ankles			Cancer			Emphysema		
Cardiac Pacemaker			Radiation Therapy			Easily Winded		
Heart Murmur			Chemotherapy			Hay Fever		
Mitral Valve Prolapse			Recent Weight Loss			Tuberculosis		
Rheumatic Fever			Sexually Transmitted Disease			Stomach Ulcers		
Sleep Apnea			Hepatitis A, B, or C			Heart Burn/Gastric Reflux		
Osteoporosis/penia			AIDS/HIV					

Do you have any problem, disease, or condition not previously listed?_____

Do you have any family history of: ☐Cardiovascular Disease ☐Diabetes ☐Cancer ☐Gum Disease ☐Dental Cavities

Medications(Rx and OTC),Vitamins, Supplements, and Herbs	Daily Dosage	Reason

Describe any hospitalizations or surgeries:

_____

_____

_____

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DENTAL HISTORY

Date of Last Exam_____

How would you describe your pattern of dental visits? □Regular □Sporadic □Only when there is a problem

Are you having any dental problems that require immediate attention?_____

Have you ever been treated by a dental specialist: □Oral Surgeon □Periodontist □Endodontist □Orthodontist □Pediatric Dentist

If so, what is the name of the specialist?_____

Are you currently being treated by a dental specialist?_____

	Yes	No		Yes	No
Do you get cavities frequently?	□	□	Do your gums bleed while brushing?	□	□
Do you feel like you have a dry mouth?	□	□	Do your gums feel swollen and tender?	□	□
Do any of the following cause you tooth discomfort?			Have you been told you have gum disease?	□	□
□Hot □ Cold □Sweets □Chewing			Have you had deep cleaning?	□	□
Do you have:			Do you have any lumps or sores in your mouth?	□	□
□Loose teeth □Worn teeth □Chipped teeth			Does your bite feel comfortable?	□	□
Have you ever been told that you have TMJ?	□	□	Do you have frequent headaches?	□	□
Is your jaw painful or tender?	□	□	Have you had trauma to your jaw?	□	□
Do your joints click or pop?	□	□	Do you clench or grind your teeth?	□	□

How often do you brush your teeth?_____ How often do you floss your teeth?_____

Do you notice plaque build-up on your teeth between brushings? □Yes □No

Do you drink liquids other than water more than 2 times daily between meals? □Yes □No _____

Do you snack daily between meals? □Yes □No Describe_____

Please tell us about the dental products you use at home on a regular basis.

□ Manual toothbrush □ Electric toothbrush Type: Hard____ Soft____ Extra-soft_____ Other_____

□ Floss □ Floss Holder □ Toothpick □ Waterpick

□ Toothpaste Brand_____ □ Mouthrinse Brand_____

□ Bleaching products Type_____

How do you feel about the appearance of your smile?_____

What improvements would you like to make in your mouth?_____

Please add anything else you feel is important concerning your dental needs: