# Ferguson Family Dentistry

8670 Ferry St, Montague, MI 49437 · (231) 894-4820

**Patient Name:** _____ **Date of Birth:** _____

Pharmacy Name: _____ Phone Number: _____

Physician's name? _____

Have you ever been told you need to Antibiotic Premedicate prior to dental appointment? ○ Yes ○ No If yes _____

Have you been hospitalized or had a major operation in the last 5 years? ○ Yes ○ No If yes _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes _____

Are you taking any medications Rx or over the counter? ○ Yes ○ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No If yes _____

**Do you take blood thinners?** ○ Yes ○ No If yes _____

Are you on a special diet? ○ Yes ○ No If yes _____

Do you use tobacco? ○ Yes ○ No If yes _____

Do you use controlled substances? ○ Yes ○ No If yes _____

Women: Are you… ○ Pregnant/Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

**Are you allergic to any of the following?** ○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex

○ Sulfa Drugs ○ Local Anesthetics ○ Other ○ None _____

**Do you have or have you had, any of the following?**

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|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ○ Yes ○ No | Drug Addiction ○ Yes ○ No | Hepatitis B or C ○ Yes ○ No | Renal Dialysis ○ Yes ○ No |
| Alzheimer's Disease ○ Yes ○ No | Easily Winded ○ Yes ○ No | High Blood Pressure ○ Yes ○ No | Rheumatic Fever ○ Yes ○ No |
| Anaphylaxis ○ Yes ○ No | Emphysema ○ Yes ○ No | High Cholesterol ○ Yes ○ No | Rheumatism ○ Yes ○ No |
| Anemia ○ Yes ○ No | Epilepsy or Seizures ○ Yes ○ No | Hives or Rash ○ Yes ○ No | Scarlet Fever ○ Yes ○ No |
| Angina ○ Yes ○ No | Excessive Bleeding ○ Yes ○ No | Hypoglycemia ○ Yes ○ No | Shingles ○ Yes ○ No |
| Arthritis/Gout ○ Yes ○ No | Excessive Thirst ○ Yes ○ No | Irregular Heartbeat ○ Yes ○ No | Sickle Cell Disease ○ Yes ○ No |
| Asthma ○ Yes ○ No | Fainting Spells/Dizziness ○ Yes ○ No | Joint Replacement ○ Yes ○ No | Sinus Trouble ○ Yes ○ No |
| Blood Disease ○ Yes ○ No | Frequent Cough ○ Yes ○ No | Kidney Problems ○ Yes ○ No | Spina Bifida ○ Yes ○ No |
| Blood Transfusion ○ Yes ○ No | Frequent Diarrhea ○ Yes ○ No | Leukemia ○ Yes ○ No | Stomach/Intestinal Disease ○ Yes ○ No |
| Breathing Problems ○ Yes ○ No | Frequent Headaches ○ Yes ○ No | Liver Disease ○ Yes ○ No | Stroke ○ Yes ○ No |
| Bruise Easily ○ Yes ○ No | Glaucoma ○ Yes ○ No | Low Blood Pressure ○ Yes ○ No | Swelling of Limbs ○ Yes ○ No |
| Cancer ○ Yes ○ No | Hay Fever ○ Yes ○ No | Lung Disease ○ Yes ○ No | Thyroid Disease ○ Yes ○ No |
| Chemotherapy ○ Yes ○ No | Heart Attack/Failure ○ Yes ○ No | Mitral Valve Prolapse ○ Yes ○ No | Tonsillitis ○ Yes ○ No |
| Chest Pains ○ Yes ○ No | Heart Murmur ○ Yes ○ No | Osteoporosis ○ Yes ○ No | Tuberculosis ○ Yes ○ No |
| Cold Sores/Fever Blisters ○ Yes ○ No | Heart Pacemaker ○ Yes ○ No | Parathyroid Disease ○ Yes ○ No | Tumors or Growths ○ Yes ○ No |
| Congenital Heart Disorder ○ Yes ○ No | Heart Trouble/Disease ○ Yes ○ No | Psychiatric Care ○ Yes ○ No | Ulcers ○ Yes ○ No |
| Cortisone Medicine ○ Yes ○ No | Hemophilia ○ Yes ○ No | Radiation Treatments ○ Yes ○ No | Venereal Disease ○ Yes ○ No |
| Diabetes ○ Yes ○ No | Hepatitis A ○ Yes ○ No | Recent Weight Loss ○ Yes ○ No | Yellow Jaundice ○ Yes ○ No |

Any other health concerns or issues not listed? _____

## NEW PATIENTS DENTAL HISTORY

Previous Dentist _____

Date of last dental exam: _____ Date of last dental x-rays _____

Has the patient had any injuries to the face, mouth, or teeth? ○ Yes ○ No
Describe _____

Do your gums bleed when you brush or floss? ○ Yes ○ No

Are your teeth sensitive to cold, hot, sweets, or pressure? ○ Yes ○ No

Does food or floss catch between your teeth? ○ Yes ○ No

Is your mouth dry? ○ Yes ○ No

Have you ever had perio (gum) treatments? ○ Yes ○ No

Have you ever had ortho (braces) treatments? ○ Yes ○ No

Have you had problems associated with previous dental treatments? ○ Yes ○ No

Is your home water fluoridated? ○ Yes ○ No

Are you currently experiencing dental pain or discomfort? ○ Yes ○ No

Do you have clicking, popping or discomfort in the jaw? ○ Yes ○ No

Do you clench or grind your teeth? ○ Yes ○ No

Do you have sores or ulcers in your mouth? ○ Yes ○ No

Do you wear dentures or partials? ○ Yes ○ No

Reviewed:

| Initial/Date | Initial/Date | Initial/Date | Initial/Date | Initial/Date |
|---|---|---|---|---|