Ashland Family Dentistry
A Division of Central Virginia Dental Care, PLC.
Louis J. Korpics, Jr., D.D.S. and Associates

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(804) 448-1102

DENTAL HISTORY

Patient Name: _____ Date: _____
Chief Complaint (reason for coming to our office): _____
_____
Date of last dental visit: _____
Reason for last dental visit: _____
Name and address of last dentist: _____

Please circle the word that best describes the current condition of your

Teeth: Poor Fair Good Excellent
Gums: Poor Fair Good Excellent

How important is it for you to save all of your teeth?
Very important_____ Sort of important_____ Not too important_____ Don't know_____

YES	NO	
☐	☐	Are you unhappy with the appearance of your teeth?
☐	☐	Have you had any difficulty with previous dental treatment?
☐	☐	Has fear kept you from seeking dental treatment?
☐	☐	Do your gums bleed when you brush your teeth?
☐	☐	Do you use dental floss?
☐	☐	Have you ever been told you had "trench mouth" or gum disease?
☐	☐	Have you ever been treated for gum disease?
☐	☐	Do you have halitosis (bad breath) or an unpleasant taste in your mouth?
☐	☐	Have you ever had any injury to your face or jaw?
☐	☐	Are there any lumps or bumps in your mouth?
☐	☐	Do you have difficulty swallowing?
☐	☐	Are your teeth sensitive to hot, cold or sweets?
☐	☐	Does your food wedge between your teeth?
☐	☐	Do you have any loose teeth?
☐	☐	Have you ever noticed any of your teeth shifting or space increasing between them?
☐	☐	Have you ever had braces on your teeth?
☐	☐	Do you hold pens, pencils, pipes or other such objects between your teeth?
☐	☐	Do you have any teeth that are sore or squeak when you chew or put pressure on them?
☐	☐	Do you have a habit of grinding or clenching your teeth together?
☐	☐	Do you have pain in the area of your ears or your jaws when you chew?
☐	☐	Does your jaw hurt when you open wide or take big bite?
☐	☐	Does your jaw make noise so that it bothers you or others?
☐	☐	Do you suffer from headaches?
☐	☐	Do you suffer from pain in the face, neck or throat?
☐	☐	Did you live in a town that had fluoridated water when you were a child?
☐	☐	Have you ever had fluoride treatment?
☐	☐	Do you use a toothpaste with fluoride in it?
☐	☐	Do you think that you get a lot of tooth decay?
☐	☐	Do you use tobacco products?

Cigarettes_____ Pipes_____ Cigars_____ Dip/Chew_____

Would you consider your appetite to be: Good_____ Fair_____ Poor_____
What is the total number of meals and snacks you have on average a day?_____
How many times per day do you eat desserts? _____
How often do you snack in between meals?
Never_____ Seldom_____ Often_____ All the time_____
What are typical snack foods for you?_____
Do you use gum and/or mints, cough drops?
a. Never_____ Seldom_____ Often_____ All the time_____
b. Sugarless_____ Regular_____

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MEDICAL HEALTH QUESTIONNAIRE

Patient Name: _____
Date: _____

This form is to be completed by the patient, parent, guardian, or family member

Gender [ ] M [ ] F
Race: _____
Are you currently under a physician's care? [ ] YES [ ] NO
Name of physician: _____ Phone #:_____
Date of last physician visit: _____ Reason: _____
Address: _____

Yes	No	
☐	☐	Have there been any changes in your general health in the last year? Explain:_____
☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? Explain:_____
☐	☐	Has your physician ever recommended that you take antibiotics prior to dental or surgical treatment?
☐	☐	Have you had an orthopedic total joint replacement or heart valve replacement? When?_____
☐	☐	Do you have a heart murmur or a history of rheumatic heart disease?
☐	☐	Have you taken cortisone (steroids) in the last 2 years?
☐	☐	Have you ever been treated for osteoporosis or osteopenia? If "Yes", When?_____
☐	☐	Do you drink any type of alcohol? Type/Amount:_____ No. of years _____
☐	☐	Do you use recreational (street) drugs? What type? _____
☐	☐	Have you ever been treated for chemical or alcohol dependency? How Long? _____
☐	☐	Do you or have you used tobacco? Type/Amount:_____ No. of years _____
☐	☐	Have you or are you taking blood thinners?
☐	☐	Have you ever taken diet pills, such as: How Long? _____

Yes	No	
☐	☐	Pondimin (fenfluramine)
☐	☐	Redux (dexphenfluramine)
☐	☐	Fen-Phen(phentermine)

Yes	No	
☐	☐	Have you ever taken any of the following bisphosphonate drugs: How Long ? _____

Yes	No	
☐	☐	Alendronate (Fosamax)
☐	☐	Residronate (Actonel)
☐	☐	Ibandronate (Boniva)
☐	☐	Pamidronate (Aredia)
☐	☐	Zoledronate (Zometa)

ALLERGIES Are you allergic to any of the following?

Yes	No		Yes	No	
☐	☐	Local anesthetic	☐	☐	Latex
☐	☐	Sleeping aid medications	☐	☐	Aspirin
☐	☐	Sulfa drugs	☐	☐	Iodine
☐	☐	Codeine or other narcotics	☐	☐	Nickel
☐	☐	Penicillin	Type of reaction:_____		
☐	☐	Other Antibiotics	Other Allergies:_____		

FEMALES ONLY

Yes	No	
☐	☐	Post-menopausal or post- hysterectomy?
☐	☐	Are you pregnant? Due date:_____
☐	☐	Are you currently breastfeeding?
☐	☐	Are you currently taking birth control medication?
☐	☐	Are you currently taking medication for osteoporosis?

SYSTEMS REVIEW –CHECK YES or NO
This form to be completed by the patient.

Patient Name_____
Date_____

Yes	No	
		1. CARDIOVASCULAR CONDITIONS
☐	☐	Angina/Chest pain/Pain on exertion
☐	☐	Atherosclerosis/Hardening of the arteries
☐	☐	Artificial heart valve date:_____
☐	☐	Internal defibrillator date:_____
☐	☐	Heart attack date:_____
☐	☐	Heart murmur
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Congenital heart defect
☐	☐	Mitral valve prolapse
☐	☐	Bypass surgery date:_____
☐	☐	Stent placement date:_____
☐	☐	Pacemaker date:_____
☐	☐	Swelling of ankles
☐	☐	Shortness of breath after mild exercise
☐	☐	Rheumatic fever or rheumatic heart disease
☐	☐	Irregular heartbeat
☐	☐	High Cholesterol

Yes	No	
		2. RESPIRATORY CONDITIONS
☐	☐	Tuberculosis
☐	☐	Emphysema
☐	☐	Chronic bronchitis
☐	☐	Asthma
☐	☐	Seasonal allergies
☐	☐	Sinusitis
☐	☐	Persistent cough or cough up blood
☐	☐	Sleep Apnea/CPAP machine

Yes	No	
		3. GASTROINTESTINAL CONDITIONS
☐	☐	Colon disorders
☐	☐	Persistent diarrhea
☐	☐	Difficulty swallowing
☐	☐	Gastroesophageal reflux/Heartburn
☐	☐	Ulcers
☐	☐	Malnutrition
☐	☐	Jaundice
☐	☐	Gallbladder trouble/stones
☐	☐	Liver disease☐ ☐
		° Hepatitis A B C
		° Cirrhosis
		° Other liver condition

Yes	No	
		4. ENDOCRINE CONDITIONS
☐	☐	Thyroid problems
☐	☐	Parathyroid problems
☐	☐	Diabetes Type:_____
☐	☐	Hypoglycemia
☐	☐	Adrenal problems

Yes	No	
		5. GENITOURINARY CONDITIONS
☐	☐	Kidney problems
☐	☐	Dialysis
☐	☐	Bladder infections

Yes	No	
		6. SEXUALLY TRANSMITTED DISEASE
☐	☐	Type:_____

Yes	No	
		7. CANCER
☐	☐	Site:_____ Type:_____
☐	☐	Chemotherapy Date:_____
☐	☐	Radiation/Cobalt therapy Date:_____
☐	☐	Surgery Date:_____

Yes	No	
		8. BONE & JOINT CONDITIONS
☐	☐	Osteoarthritis
☐	☐	Osteoporosis
☐	☐	Traumatic injury
☐	☐	TMJ problems
☐	☐	Jaw surgery
☐	☐	Frequent fractures
☐	☐	Rheumatoid arthritis
☐	☐	Joint replacement/ Pre-med needed? _____

Yes	No	
		9. BLOOD ABNORMALITIES
☐	☐	Prolonged bleeding
☐	☐	Anemia
☐	☐	Sickle cell disease:_____ Trait:_____
☐	☐	Hemophilia Type:_____
☐	☐	Blood Transfusion Year: _____
		Explain circumstances_____
		_____
		_____

Yes	No	
		10. NEUROLOGIC CONDITIONS
☐	☐	Epilepsy
☐	☐	Convulsions/Seizures
☐	☐	Stroke
☐	☐	Neuritis
☐	☐	Neuralgia/Tics
☐	☐	Numbness/Paralysis
☐	☐	Severe frequent headaches
		° Migraines
		° Repeated blackouts/Fainting
☐	☐	Chronic facial pain

Yes	No	
		11. PSYCHOLOGICAL CONDITIONS
☐	☐	Depression
☐	☐	Anxiety or panic disorders
☐	☐	Bipolar disease
☐	☐	Eating disorder, anorexia, buliemia, etc.
☐	☐	Other psychological conditions
☐	☐	ADD/ADHD
☐	☐	Autism

Yes	No	
		12. DERMATOLOGIC CONDITIONS
☐	☐	Chronic/Recurrent skin rash
☐	☐	Psoriasis
☐	☐	Eczema
☐	☐	Other: _____

Yes	No	
		13. IMMUNE CONDITIONS
☐	☐	AIDS or HIV infection
☐	☐	Lupus erythematosis
☐	☐	Sarcoidosis
☐	☐	Immunosuppression
		° drug induced:_____
		° radiation induced:_____
		° Other immune disease:_____

Yes	No	
		14. OTHER CONDITIONS
☐	☐	Domestic violence victim
☐	☐	Hearing loss/ hearing aids
☐	☐	Glaucoma
☐	☐	Organ/Tissue transplant:_____
☐	☐	Night sweats
☐	☐	Unintended weight loss
☐	☐	Chronic pain Site:_____

Patient Name: _____
Date: _____

This form to be completed by the patient and reviewed by the clinician.

CURRENT MEDICATIONS (Including Prescribed, Over-the-Counter and Herbal or Natural)

If you have a list of medications you would like to attach to this form, please check here: ◯

If you are **NOT** taking any medications, please check here: ◯

TO BE COMPLETED BY THE PATIENT

Name of Medication	**Dose/Day**	**Date Started**

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Date: _____ **Signature:** _____

If other than the patient, Indicate relationship: parent or legal guardian: _____