# Medical History

Patient Name: _____

Name of personal physician: _____

Physician Address: (city, state)_____ Phone Number: _____

**Date of last medical exam**: _____ Current health condition: ☐Excellent ☐Good ☐ Fair ☐ Poor

(For Women) Are you currently pregnant? ☐ yes ☐ no If yes, how many months? _____

Please list any medications (Prescription, IV, Over the counter) you take: _____

_____

Please list vitamin/herbal supplements: _____

Do you know your blood pressure? ☐ yes ☐ no (If yes, what is your normal range?) _____

**Please check if you're allergic to any of the following:**

- ☐ Local Anesthetics
- ☐ Penicillin/other antibiotics
- ☐ Barbiturates, sedatives, sleeping pills
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Shellfish, iodine or red wine
- ☐ Codeine/other narcotics
- ☐ Latex sensitivity
- ☐ Other _____

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

- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Arthritis/Gout
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemical Addiction
- ☐ Chemotherapy
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells/Dizziness
- ☐ Kidney Problems
- ☐ GERD
- ☐ Heart Attack/Failure
- ☐ Congenital Heart Disorder
- ☐ Heart Trouble/Disease
- ☐ Irregular Heartbeat
- ☐ Abnormal Blood Pressure
- ☐ Hemophilia
- ☐ Prolonged Bleeding
- ☐ Stroke
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Ulcers
- ☐ Stomach Problem
- ☐ Leukemia
- ☐ ***Heart Pace Maker***
- ☐ ***Endocarditis***
- ☐ ***Cold Sores***
- ☐ ***Osteoporosis***
- ☐ ***Bisphosphonates***
- ☐ ***Tuberculosis***
- ☐ ***Diabetes***
- ☐ Artificial Joint
- ☐ Frequent Headaches
- ☐ Sinus Trouble
- ☐ Shingles
- ☐ Rheumatism
- ☐ Psychiatric Care
- ☐ ***AIDS/HIV Positive***
- ☐ ***Artificial heart Valve***
- ☐ ***Organ Transplant***
- ☐ ***Hepatitis A, B, or C***
- ☐ ***Corticosteriods***
- ☐ ***Excessive Bleeding***
- ☐ ***Renal Dialysis***
- ☐ ***Radiation Treatment***
- ☐ ***Thyroid Disease***
- ☐ ***Tobacco Use*** *(please circle)*

  Smoking / Chew / E-cigs

  History _____

**Please explain any yes the conditions above or you have had any serious illness in past 5 years not listed?**

_____

_____

_____

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). Initial: _____

**Consent:** I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

*The information I have given above is true and accurate to the best of my knowledge. If I filled this form out incorrectly or with held information I will not hold this office responsible for any possible negative outcomes.*

Signature _____ Date _____

Dr. Michael D. Wasco DDS LLC 987 C East Cherry St. Canal Fulton, OH 44614

# Getting to Know You

| | | |
|---|---|---|
| Name: | | ☐ Female ☐ Male |
| Address: | | |
| DOB: | Social Security# | |
| Home # | Cell# | Work # |
| Email Address: | May we use cell to contact you: ☐ Y ☐ N<br>May we use email to contact: ☐ Y ☐ N | |
| Name of Emergency Contact: | Phone # | |
| If you were referred, whom may we thank for referring you? | | |
| How did you find us?<br>☐ Mailing Flyer ☐ Insurance Plan Book ☐ Website wascodental.com<br>☐ Facebook ☐ Google Search ☐ Other:_____ | | |

# DENTAL HISTORY

Former Dentist: _____ When did you last visit a dentist?_____

Are you aware of any dental problems? ☐ yes ☐ no

Explain:_____

Please Rate the current condition of mouth. **Poor** 1 2 3 4 5 **Excellent**

Please Rate Appearance of your smile. **Poor** 1 2 3 4 5 **Excellent**

Would you like whiter teeth ?..... ☐ yes ☐ no

Have you ever been treated for gum disease (periodontal disease)?..... ☐ yes ☐ no

Are your teeth sensitive to: ..... ☐ Nothing ☐ Sweets ☐ Hot ☐ Cold ☐ Pressure/Chewing

Are you concerned with Bad Breath (Malodor)? ..... ☐ yes ☐ no

Are you concerned with Sleep APNEA ?..... ☐ yes ☐ no

Are you concerned with grinding or clenching your teeth? ..... ☐ yes ☐ no

Do you wear a bite guard? ..... ☐ yes ☐ no

Are you aware of TMJ problems –Jaw Clicks, pops, pain, lock up? ☐ yes ☐ no Side: ☐ Right ☐ Left ☐ Both

What is your level of anxiety to dental procedures? ..... Low Moderate High Extreme

If you could change anything about your smile what would that be?

_____

Is there anything else that would be valuable for your dentist to know to best care for you?

_____

Initial dental/medical health reviewed by:

_____ Date____/____/____

Dental/Medical reviewed: *(initials and date)*