Brian A. Eness DDS

Medical History and Information

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Name: *Last:* *First:*	Home Phone:	Cell Phone:
Address:	City, State, Zip Code:	
Occupation:	Date of Birth:	Sex: **M F**
Name of Physician:	Primary Pharmacy:	
Are you currently under the care of a physician? **YES NO** If yes, please explain: _____		
Emergency Contact: Relationship:	Home Phone:	Cell Phone:

HEALTH INFORMATION: Do you currently have, or have you ever had, the following medical conditions?

YES NO Artificial (Prosthetic) Heart Valve
YES NO Previous Infective Endocarditis (Heart)
YES NO Heart Transplant
YES NO Congenital Heart Disease (CHD)
Unrepaired or Repaired CHD with residual defects?

YES NO Joint Replacement? (Hip, Knee, etc.)
(if yes, location and date:_____)
(Any complications or revisions?_____)

YES NO Have you taken or are you taking an anti-resorptive medication (bisphosphonate)(such as: Fosamax, Actonel, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? (low bone density)

YES NO Heart Disease
YES NO Chest Pain/Angina
YES NO Congestive Heart Failure
YES NO Heart Attack/Stroke (if yes date:_____)
YES NO Heart Surgery/Pacemaker/Defibrillator
YES NO High Blood Pressure
YES NO Blood Disorders
YES NO Spleen Removal
YES NO Do you take any Blood Thinners?
YES NO Anemia
YES NO Hemophilia/Abnormally Prolonged Bleeding
YES NO Liver Disease/Jaundice
YES NO Hepatitis

YES NO Respiratory Disease
YES NO Asthma
YES NO Emphysema
YES NO Tuberculosis
YES NO Stomach Ulcer/Frequent Heartburn
YES NO Eating Disorder
YES NO Kidney Problems
YES NO Diabetes (type I or II)
YES NO Thyroid Disease
YES NO Arthritis or Dexterity problems
YES NO Epilepsy/Seizures/Fainting
YES NO Decreased immunity
YES NO Cancer or Leukemia (type _____)
YES NO Chemotherapy/Radiation
YES NO Rheumatoid Arthritis
YES NO Autoimmune Disease (e.g. Systemic Lupus)
YES NO HIV/AIDS
YES NO Hearing Impairment
YES NO Glaucoma
YES NO Sinus Problems
YES NO Infectious Diseases
YES NO Alcohol Abuse
YES NO Substance Abuse
YES NO Tobacco use
YES NO Behavioral/Mental Health Conditions
YES NO Depression

*** *Please continue on the next page.* ***

YES NO Have you ever had a major surgery? (if yes, surgery & date:_____)	**YES NO** Any other medical conditions? (if yes, list here: _____)

Women: Are you pregnant? **YES NO** Due date:_____

DENTAL INFORMATION:

YES NO Do your gums bleed when you brush or floss? **YES NO** Are your teeth sensitive to cold, hot, or pressure? **YES NO** Is your mouth dry? **YES NO** Have you had any periodontal (gum) treatment? **YES NO** Have you had orthodontic treatment (braces)? **YES NO** Do you like your smile?	**YES NO** Are you currently experiencing dental pain? **YES NO** Do you have any clicking, popping, or discomfort in your jaw? **YES NO** Do you brux or grind your teeth? **YES NO** Do you have sores or ulcers in your mouth? **YES NO** Do you wear dentures or partials?
Date of your last dental exam or dental visit?	What was done at that time?
What is the reason for your visit today?	

ALLERGIES:

Are you allergic to or do you suffer ill effects from any of the following? **NONE**

- □ Penicillin
- □ Other Antibiotics _____
- □ Codeine or narcotics
- □ Other allergies _____
- □ Latex/Rubber
- □ Aspirin or Ibuprofen
- □ Dental Anesthesia
- □ Metals (e.g. Nickel, etc.)

MEDICATIONS: Please list any medications, including over-the-counter, “natural” supplements, or vitamins.

_____

_____

_____

Signature: _____ **Date:** _____

Comments/Updates:

Reviewed by Patient:

Initials: _____ Date: _____ Initials: _____ Date: _____

Initials: _____ Date: _____ Initials: _____ Date: _____

Initials: _____ Date: _____ Initials: _____ Date: _____