Michael D. Eickman DDS

Thief River Falls Family Dentistry, PA

Medical Dental History Form

Today's Date:	Patient Name:
Date of Birth:	Most recent hospitalization: ___/___/___ Reason:
Current Physician:	Physician Phone:
Physician Address:	
Emergency Contact:	Relation:

Current Medications (Prescription, Over the counter and Herbal)

Drug	Reason

Allergies (check all that apply)

- □ Penicillin or other Antibiotics
- □ Aspirin
- □ Sulfa Drugs
- □ Metals (e.g. nickel)
- □ Local Anesthetics
- □ Hay Fever (seasonal)
- □ Latex
- □ Iodine
- □ Other (please list) ____________________

Do you have or have you had or experienced any of the following? Check all that apply:

□ High Blood Pressure	□ Stroke (blood thinners □)	□ Persistent Cough	□ Cancer
□ Heart Attack date___/___/___	□ Anemia	□ Lung Problems/ Short of Breath	□ Chemo or Radiation Therapy
□ Angina Pectoris (Chest Pains)	□ Leukemia	□ Emphysema/ COPD	□ AIDS/ HIV
□ Pacemaker	□ Bruise Easily	□ Tuberculosis	□ Drug/Alcohol Addiction
□ Congenital Heart Defect	□ Hemophilia	□ Asthma	□ Eating Disorder
□ Prosthetic Heart Valve	□ Hepatitis (A B C)/Jaundice	□ Sinus Trouble	□ Psychiatric Treatment
□ Heart Surgery	□ Liver Disease	□ Thyroid Problems	□ Use controlled substances
□ Arthritis	□ Kidney Disease/ Trouble	□ Fainting/Seizures/Epilepsy	□ Glaucoma
□ Joint Replacement	□ Stomach Troubles/ Ulcers	□ Diabetes What Type: (HbA1C=_______)	
□ Oral/IV Bisphosphonate drugs(e.g. Fozamax, Aredia, Zometa) Dates Used: What Reason:			
□ Ever used Tobacco? What Type:		How much/often:	□ Cold Sores
□ Pregnant or Trying	□ Nursing	□ Taking Oral Contraceptives	□ Anaphylaxis

□Do you suffer from anything not listed above? ____________________

Dental History (check all that apply)

What is your primary reason for seeing us today? (e.g. pain, sensitivity, checkup, etc)____________________

Previous dentist:	Date of Last Dental Visit: ____ /____ /____
How often do you brush your teeth?	Do you Floss? YES NO How often?
□ Dental Pain at this time	□ Swelling or Lumps in mouth, head, or neck
□ My gums ever bleed when brush or floss	□ Clench or Grind teeth (Wake/Sleep/Both)
□ Teeth sensitive to hot or cold	□ Jaw clicking
□ Teeth sensitive to sweet or sour	□ Jaw joint Pain (TMJ/TMD)
□ Difficult extractions in past	□ Difficulty opening/closing/chewing
□ Prolonged Bleeding after past extractions	□ Frequent headaches
□ I have Dentures or Partials	□ Ever had orthodontic treatment (e.g braces)
□ I have fear and/or anxiety with dental treatment	□ Face or Jaw injury
□ I would like straighter teeth	□ I would like whiter teeth
□ I DO NOT want to keep my natural teeth	How do you feel about your teeth? (write below)

Comments____________________