# East Boise Dental

Todd R Broyles DDS

Name ______________________ Address ______________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ______________________ Birthdate ______________

| | YES | NO |
|---|---|---|
| 1. Are you under medical treatment now? If yes, please explain ______________________ | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain ______________________ | ☐ | ☐ |
| 3. Have you ever taken Bisphosphonates as part of cancer or osteoporsis treatments? | ☐ | ☐ |
| 4. Have you ever taken any weight loss medication? | ☐ | ☐ |
| 5. Do you use tobacco? | ☐ | ☐ |
| 6. Do you use any controlled substances? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 7. Are you allergic to or have you had any reactions to the following: | | |
| Local Anesthetics (e.g. novacain) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Others ______________ | ☐ | ☐ |
| 8. Have you ever been told you should take an antibiotic medication prior to dental treatment? | ☐ | ☐ |
| 9. Women Only: | | |
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking oral contraceptives? | ☐ | ☐ |

## PLEASE LIST ANY MEDICATIONS YOU ARE TAKING (INCLUDING NON-PRESCRIPTIONS MEDICATIONS)

| Medication name(s) | Amounts/times per day | Reasons for taking |
|---|---|---|
| | | |
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## DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| AIDS or HIV infection | ☐ | ☐ | Epilepsy/Convulsions | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Anemia | ☐ | ☐ | Fainting/Seizures | ☐ | ☐ | Migraines | ☐ | ☐ |
| Angina | ☐ | ☐ | Glaucoma | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Hay Fever/Allergies | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| Asthma | ☐ | ☐ | Heart Attack | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Auto Immune Disease | ☐ | ☐ | Heart Disease | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ |
| Back Problems | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stomach Troubles/Ulcers | ☐ | ☐ |
| Bloodthinner | ☐ | ☐ | Hepatitis/Type ________ | ☐ | ☐ | Stroke | ☐ | ☐ |
| Cancer | ☐ | ☐ | Herpes/Cold Sores | ☐ | ☐ | Taking Asprin | ☐ | ☐ |
| Cardiac Pacemaker | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Thyroid Problem | ☐ | ☐ |
| Circulatory Problems | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Jaundice | ☐ | ☐ | Tumors | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Kidney Disease | ☐ | ☐ | | | |

**ANY OTHER HEALTH CONCERNS WE SHOULD BE AWARE OF?** ______________________

Over Please

# PATIENT DENTAL HISTORY

Name of Previous Dentist ______________________ Date of Last Exam ______________

Previous Dentist's Location ______________________ Date of Last Cleaning ______________

Chief Dental Concern ______________________

| | YES | NO |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are you in pain now? | ☐ | ☐ |
| 4. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 5. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 6. Have you ever experienced problems in your jaw? | ☐ | ☐ |
| 7. Do you have frequent headaches? | ☐ | ☐ |
| 8. Do you clench or grind your teeth? | ☐ | ☐ |
| 9. Do you experience dry mouth? | ☐ | ☐ |
| 10. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 11. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 12. Have you had any orthodontic treatment? | ☐ | ☐ |
| 13. Have you ever been told that you have periodontal or "gum" disease? | ☐ | ☐ |
| 14. Have you ever had periodontal or "gum" surgery | ☐ | ☐ |
| 15. Do you wear dentures or partials? | ☐ | ☐ |
| If yes, date of placement ______________ | | |
| 16. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 17. Are you satisfied with the current condition of your teeth? | ☐ | ☐ |

18. If you could change the appearance of your teeth, what would you change? ______________________

______________________

Name of Primary Physician ______________________ Date of Last Exam: ______________________

| Name of Surgeon or Physician | Type of Surgery / Treatment | Date of Surgery / Exam |
|---|---|---|
| | | |
| | | |
| | | |

*The above information is accurate to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I accept any mutually agreed upon dental anesthetics or treatment that my dentist feels are necessary in my care.*

Signature ______________________ Date ______________

# PATIENT MEDICAL HISTORY UPDATE

| Change | Signature | Date |
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