Stanley F. Kayes, DDS
Medical History

Name_____ Date_____
(Please use your full legal name as listed with your insurance plan)

Personal Medical History
Please circle any that apply and explain below if necessary.

Heart Disease	Hepatitis	High Blood Pressure	Cancer	Chronic Headaches	Acid reflux
Heart Murmur	HIV Positive	Glaucoma	Diabetes	Head Injury	Bulimia
Mitrovalve Prolapse	AIDS	Liver Problems	Asthma	Stroke	Pregnancy
Rheumatic Fever	Herpes	Kidney Disease	Respiratory Problems	Jaw Injury	Allergies
Artificial Joints	Cold Sores	Thyroid Problems	Clotting Problems	Arthritis	
Organ Transplant	Tuberculosis	Epilepsy, Seizures	Anemia	Chronic Sinus Problems	

Please explain any condition listed above or detail any other medical condition _____

_____

List any allergies or drug reactions, including penicillin_____

Past or present conditions relating to drug or alcohol use - Please check if you need to discuss this with us _____
Please note: If you have any present or past problems with alcohol or drugs, we do need you to tell us. This is kept confidential but is important for us to know since even past use can cause permanent changes to liver or kidney function. If organ damage has occurred it can cause serious medical consequences if certain dental anesthetics are used.

Family and Social Medical/Dental History
Is there a family history of heart disease, stroke, diabetes, or periodontal disease?_____
Do you have a close relationship or live with someone with periodontal disease or serious dental decay problems? _____

Medication Review and Dry Mouth Screening (If you need more space, use back of form**)**
Please list all medications you are taking and the conditions you are taking them for

_____

_____
Do you have any mouth burning sensation or gum tissue soreness? _____Do you have any bad taste in your mouth?_____

Oral Cancer Risk Screening (Please check any that apply)
Smoker _____ Other tobacco use_____ Tobacco use in the past_____
Is your diet low in fruits or vegetables?____ Are you over forty?_____ Have you noticed unusual spots in your mouth?_____
How many times per week would you estimate you have one or more servings of beer, wine or other alcoholic beverage?_____

Chemical Acid Erosion Screening
How often do you consume beverages or foods that are sugary or acidic? This includes sodas, diet sodas, fruit drinks, juices, sports drinks, or any drinks with phosphoric or citric acid. Never_____ Once a week or less____ A few times a week_____Daily_____
Do you have any medical conditions that include problems with vomiting? _____

Screening for Cavities, Gum Disease, TMJ (Please check any that apply)
Do you have any tooth pain or sensitivity ?_____Do you have bleeding gums?_____
Have you had unexplained headaches, jaw, or facial pain?_____
Is your diet high in sugar?_____ Are you taking any syrupy medications?_____
Do you consume dairy products daily or take a calcium supplement?_____
Is your water supply fluoridated?_____

Dental Care History
Approximate date of last dental exam _____ Approximate date of last x-rays _____
Have you ever had any reaction to a dental anesthetic? Explain _____
Have you had any problems with dental care in the past? Explain _____

Signature _____ Medical history reviewed by _____ Date_____