liguanea FAMILY DENTAL

HD. Lawson-Myers, D.D.S.

Patient Dental and Medical History

PATIENT NAME _____ DATE _____

Primary Reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

Please Circle

Name of previous dentist (Optional) _____

Would you describe your present dental health as good? Comment _____	Yes	No
Do you think you have active decay or gum disease? _____	Yes	No
Do your gums ever bleed? Discuss _____	Yes	No
Do you brush and floss on a routine basis? Discuss _____	Yes	No
Do you ever feel nervous about having dental treatment? _____	Yes	No
Have you ever had a bad experience in a dental office? Describe _____	Yes	No
Do you want to keep your remaining teeth? _____	Yes	No
Do you like your smile? Why? _____	Yes	No
Do you have a specific dental problem? Describe _____	Yes	No
Do you ever brux or grind your teeth? Discuss _____	Yes	No
Have you ever had Orthodontic treatment (tooth straightening)? _____	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss _____	Yes	No

MEDICAL HISTORY

Medical Doctor's name? _____

Are you under your doctor's care now? Why? _____	Yes	No
Have you been hospitalized in the last two years? Why? _____	Yes	No
Are you taking any medications, pills or drugs? Why? _____	Yes	No
Are you allergic to any medication or substance? What? _____	Yes	No
Are you pregnant? _____	Yes	No

Please tick if you have any of the following:

☐ Heart trouble	☐ Shortness of breath	☐ Heart murmur	☐ Sickle Cell Anaemia	☐ Asthma
☐ Chest pain	☐ Epilepsy or seizures	☐ Rheumatic Fever	☐ Arthritis/Gout	☐ Emphysema
☐ Parathyroid disease	☐ Congenital heart lesion	☐ Thyroid disease	☐ Cancer	☐ Ulcers
☐ Artificial heart valve	☐ Heart Pace-maker	☐ Sinus trouble	☐ Tuberculosis	☐ Hay Fever
☐ Pain in jaw joints	☐ Drug addiction	☐ Heart surgery	☐ Diabetes	☐ Stroke
☐ Low blood pressure	☐ Scarlet Fever	☐ Blood disease	☐ Liver disease	☐ Anaemia
☐ X-Ray or Cobalt	☐ Psychiatric care	☐ Kidney disease	☐ Hypoglycemia	☐ Rheumatism
☐ Fainting / dizziness	☐ High blood pressure	☐ Glaucoma	☐ Allergies	☐ Herpes
☐ Excessive thirst	☐ Artificial joint/hip	☐ Venereal disease	☐ Cold sores	☐ Bruise easily
☐ Frequent cough	☐ Lung disease	☐ Hemophilia	☐ Blood transfusion	☐ Osteoporosis
☐ Hepatitis A (infect)	☐ Chemotherapy/radiation	☐ Yellow jaundice	☐ Nervousness	☐ HIV/AIDS
☐ Hepatitis B (Scrum)	☐ Cortisone medicine	☐ Fever blisters	☐ Swelling (feet/ankle/hand)	☐ High Cholesterol

☐ Autism

Have you ever had any other serious illness not ticked above? _____ Yes No

Please describe in detail _____

_____

Do you wish to speak with the doctor privately about any problem? _____ Yes No

_____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

MEDICAL UPDATES

I have read my medical history and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient Signature	BP	Reviewed By
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____

EPWORTH SLEEPINESS SCORE

The **Epworth Sleepiness Scale** is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on the test below you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.
Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Please score yourself in each of the situations below and then total to get an idea of your Epworth Score.

Situation	**Chance of Dozing or Sleeping**
(a) Sitting and reading	_____
(b) Watching TV	_____
(c) Sitting inactive in a public place	_____
(d) Being a passenger in a motor vehicle for an hour or more	_____
(e) Lying down in the afternoon	_____
(f) Sitting and talking to someone	_____
(g) Sitting quietly after lunch (no alcohol)	_____
(h) Stopped for a few minutes in traffic while driving	_____
Total Score (This is your Epworth Score)	_____

MEDICAL UPDATES

I have read my medical history and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient Signature	BP	Reviewed By
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____
_____	NONE	_____	_____	DR. _____

Sections **1** and **4** must be completed by all patients. Sections **2** and **3** must be completed by the relevant persons where applicable.

SECTION 1: NEW PATIENT INFORMATION

Date_____ Male ☐ Female ☐ Child ☐ Adult ☐

Patient's Name: Mr / Mrs /Miss_____
Last First Middle Preferred Name

Address_____

Date of Birth (DD/MM/YYYY)_____Email_____

Home Phone _____ Work Phone_____ Cell Phone_____

Occupation_____ Employer_____

Employer's Address_____

Who may we thank for your referral? ☐ Facebook ☐ Website Ref. Name _____Other_____

Please select appointment time preferences: AM ☐ PM ☐ Mon☐ Tue☐ Wed☐ Thu☐ Fri☐ Sat☐

SECTION 2: PARENT OR GUARDIAN

Name: Mr/Mrs/Miss_____
Last First Middle

Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐

Date of Birth (DD/MM/YYYY)_____Address_____

Relationship to Patient_____ Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____ Employer's Address_____

Spouse's Name_____
Last First Middle

Relationship to Patient_____ Email_____

Date of Birth (DD/MM/YYYY)_____Address_____

Home Phone_____ Work Phone_____ Cell Phone 1_____ Cell Phone 2_____

Employer_____ Employer's address _____

SECTION 3: INSURANCE INFORMATION

Insurance Company: 1)_____ 2)_____

Policy Number 1)_____ 2) _____

Member Name 1)_____ 2) _____

SECTION 4: EMERGENCY INFORMATION

Name of nearest relative/friend not living with you_____

Complete Address_____ Work Phone_____ Cell Phone_____