Cosmetic & Implant Dentistry of Kansas City

www.cosmeticandimplantdentistrykc.com info@dentistrykc.com
2101 Charlotte Street | Suite 330 • Kansas City, MO 64108 (816)897-4288

HEALTH HISTORY UPDATE

Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

Are you in good health? ◯ Yes ◯ No

Please list all medications you take (even over the counter):

____

____

Please list all allergies to medications:

____

____

Please check the box for any of the following conditions you have or have had.

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergy - Aspirin
☐ Allergy - Codeine	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Angina/Chest Pain	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Auto Immune Disorder	☐ Birth Control	☐ Blood Disease
☐ Cancer	☐ Chemotherapy	☐ Cortisone Treatment	☐ Currently Nursing
☐ Currently Pregnant	☐ Depression/Anxiety	☐ Diabetes	☐ Epilepsy/Seizure
☐ Excessive Bleeding	☐ Fainting	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur/MVP	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/AIDS	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease
☐ Mental Disorders	☐ Nervous Disorders	☐ Organ/CellTransplant	☐ Osteoporosis
☐ Pacemaker/Defib	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Seasonal Allergies	☐ Sinus Problems	☐ Sleep Apnea	☐ Stomach Problems
☐ Stroke/TIA	☐ Thyroid Disorder	☐ TMD/TMJ	☐ Tobacco/Vapor Use
☐ Tuberculosis	☐ Ulcers	☐ x - OTHER	

Describe checked answers and include any information not listed above:

____

____

Please list any hospitalizations since your last appointment at our office:

____

____

Is there anything about your medical history that has not been addressed on this form? Please describe:

____

____

Are you currently seeing a physician for any reason? If so, please list type of care, name and address of physician:

____

____

Please list preferred pharmacy and pharmacy phone number: ____________________

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

SOCIAL HISTORY

Do you use tobacco? ◯ Yes ◯ No

Please list tobacco type and frequency/amount of usage if applicable. ____________________

If yes, are you interested in receiving information to stop? ◯ Yes ◯ No

How frequently do you consume alcohol?

◯ Rarely or Never ◯ Monthly ◯ Weekly ◯ Daily

How frequently do you use recreational drugs?

◯ Never ◯ Rarely (1-4 times per year) ◯ Infrequently (5-11 times per year) ◯ Occasionally (1-3 times per month)

◯ Frequently (4+ times per month) ◯ Previous usage

Please list type of drug: ____________________

ORAL HEALTH

What kind of toothbrush do you usually use?

◯ Hard ◯ Medium ◯ Soft ◯ Electric

How many times per day do you brush your teeth?

◯ <1 ◯ 1 ◯ 2-3 ◯ 4+

How frequently do you floss?

◯ Rarely or Never ◯ Occasionally (2-6 times per month) ◯ Frequently (3-6 times per week) ◯ Daily

Do you have any concerns or pain with your mouth? If so, please explain.

____

____

Are your teeth:

☐ Chipped ☐ Protruding ☐ Crooked ☐ Discolored

Are you pleased with the appearance of your teeth when you smile? ◯ Yes ◯ No

Are you satisfied with the color of your teeth? ◯ Yes ◯ No

Are you happy with the shape of your teeth? ◯ Yes ◯ No

Do you like the look of your existing dental work? ◯ Yes ◯ No

Do you eat sugary foods, drinks, gum or mints between meals? ◯ Yes ◯ No

Do you experience dry mouth? ◯ Yes ◯ No

Response Date: __________