lawrence
periodontics & implants

Dr. Andrew Shelby, DMD, MS
Diplomate of American Board of Periodontology

4505 W 6th Street, Suite B
Lawrence, KS 66049
Tel: (785) 841-1188 Fax: (785) 841-1469

MEDICAL HISTORY FORM

Name: _____
[Last] [First] [Middle]

Date: _____ Date of Birth: _____ Height in feet: _____ Inches: _____ Weight (lbs):_____

Who referred you to us? _____

PLEASE CIRCLE YOU RESPONSES (YES, NO, ***DK = DON'T KNOW***) TO INDICATE IF YOU HAVE, HAVE NOT OR DO NOT KNOW IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS.

GENERAL MEDICAL INFORMATION:

YES NO DK Are you, or have you been in the past year, seen by a primary care provider (regular doctor)?
If yes, please list name and location: _____

YES NO DK Are you being seen by any medical specialists? If yes, please list name(s) and location(s): _____
_____
_____

YES NO DK Do you have active tuberculosis or have you been exposed to anyone with tuberculosis? Specify: _____

YES NO DK Have you had heart surgery? If yes, please specify: **STENTS VALVES BYPASS (CABG)** Other: _____
Date(s) and any complications: _____

YES NO DK Have you had an organ/bone marrow transplant? Specify: **HEART LUNG KIDNEY LIVER BMT** Other: _____
Date(s) and any complications: _____

YES NO DK Have you had an orthopedic total joint replacement? If yes, please specify: **HIP KNEE OTHER:** _____
Date(s) and any complications: _____

YES NO DK Do you now or have you ever had cancer? If yes, how was it treated?
- ☐ **Surgery:** diagnosis, site, when: _____
- ☐ **Radiation:** diagnosis, site, when: _____
- ☐ **Chemotherapy:** diagnosis, site, when: _____
- ☐ **Medication** to prevent or treat bone complications: If yes please specify:
  ☐ **Xgeva** (Denosumab) ☐ **Aredia** (Pamidronate) ☐ **Zometa** (Zoledronic Acid) Length of time taken: _____

YES NO DK Have you had any serious illness, surgery, or been hospitalized? If yes, how long ago?
0-12 Months Specify: _____
0-5 Years Specify: _____
>5 Years Specify: _____

YES NO DK Problems with General Anesthesia: ☐ Difficult intubation ☐ Malignant hyperthermia ☐ Prolonged/difficulty waking
☐ Post-operative nausea and vomiting ☐ Other: (Specify): _____

YES NO DK Do you use or have you used tobacco products? If yes, please specify type:
CIGARETTES E-CIGARETTES CIGARS PIPES HOOKAH SNUFF CHEW OTHER: _____
- ☐ **PAST:** When did you stop? _____ How many years of use? _____
- ☐ **CURRENT:** ☐ > 10 per day ☐ < 10 per day ☐ Occasionally For how many years: _____
  How interested are you in stopping? **VERY SOMEWHAT NOT INTERESTED**

YES NO DK Do you drink alcoholic beverages? If yes, daily? **YES NO DK** How many drinks per week? _____

YES NO DK Do you use or have you used street drugs, prescription or other substances for recreational purposes? (Specify):
☐ **PAST** ☐ **CURRENT** Are you drug dependent? **YES NO DK** Last Use: _____
(Specify): **COCAINE ECSTASY HEROIN MARIJUANA METH OPIODS Other:** _____

MEDICAL CONDITIONS: Do you have (or have you had) any of the following diseases, problems or symptoms?

YES NO DK Eye / Ear/ Nose / Throat problems

***If yes, please specify*:**

- ☐ Vision problems
  - ☐ Corrective lenses
  - ☐ Cataracts
  - ☐ Glaucoma
    - ☐ Narrow angle/Open angle
  - ☐ Macular degeneration
- ☐ Hearing impairment
- ☐ Hay fever / seasonal (allergic rhinitis)
- ☐ Other: _____

YES NO DK Heart / Blood Pressure problems

***If yes, please specify*:**

- ☐ High Blood pressure
- ☐ High cholesterol / high triglycerides
- ☐ Infective endocarditis
- ☐ Congenital heart defect / disease
- ☐ Angina (chest pain)
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Coronary heart disease
- ☐ Arrythmia (irregular heartbeat)
- ☐ Pacemaker / Implanted defibrillator
- ☐ Other: _____

YES NO DK Breathing / Lung problems

***If yes, please specify*:**

- ☐ Asthma
- ☐ Emphysema / COPD
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Obstructive sleep apnea
  - ☐ Use CPAP / BiPAP
  - ☐ Surgical correction
  - ☐ Oral appliance
- ☐ Other: _____

YES NO DK Stomach / Intestine / Liver disorder

***If yes, please specify*:**

- ☐ Acid reflux (GERD)
- ☐ Ulcers
- ☐ Crohn's disease
- ☐ IBS
- ☐ Ulcerative colitis
- ☐ Celiac disease
- ☐ Hepatitis
  - ☐ A ☐ B/D ☐ C
- ☐ Cirrhosis
- ☐ Other: _____

YES NO DK Eating disorder

***If yes, please specify*:**

- ☐ Bulimia
- ☐ Anorexia
- ☐ Other: _____

YES NO DK Kidney / Urinary disorder

***If yes, please specify*:**

- ☐ Chronic kidney disease
- ☐ Renal failure / Dialysis
- ☐ Bladder problems
- ☐ Urinary incontinence
- ☐ BPH (Benign Prostate Hypertrophy)
- ☐ Other: _____

YES NO DK Muscle / Bone disorder

***If yes, please specify*:**

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Gout
- ☐ Temporomandibular joint disorder
- ☐ Fibromyalgia
- ☐ Other: _____

YES NO DK Skin problems

***If yes, please specify*:**

_____

YES NO DK Neurologic / Nerve problems

***If yes, please specify*:**

- ☐ Stroke
- ☐ TIA (Transient Ischemic Attack)
- ☐ Seizures / Epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Neuropathies (tingling, numbness)
- ☐ Dementia / Alzheimer's (memory loss)
- ☐ Autism
- ☐ Headaches
- ☐ Other: _____

YES NO DK Mental Health disorder

***If yes, please specify*:**

- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ PTSD (Post Traumatic Stress Disorder)
- ☐ ADD / ADHD (Attention Deficit Disorder)
- ☐ Generalized anxiety disorder
- ☐ Panic attacks
- ☐ Other: _____

YES NO DK Diabetes / Endocrine disorder

***If yes, please specify*:**

- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2
- ☐ Thyroid problems
  - ☐ Hypothyroidism (low)
  - ☐ Hyperthyroidism (high)
- ☐ Other: _____

YES NO DK Blood / Hematologic disorder

***If yes, please specify*:**

- ☐ Anemia
- ☐ Sickle cell disease / trait
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple myeloma
- ☐ Bleeding disorders
  - ☐ Hemophilia
  - ☐ von Willebrand Disease
  - ☐ Thrombocytopenia (low platelets)
- ☐ Other: _____

YES NO DK Immune System disorder

***If yes, please specify*:**

- ☐ Lupus erythematous
- ☐ Rheumatoid arthritis
- ☐ Sjogren's syndrome
- ☐ Other: _____

YES NO DK Infectious disease

***If yes, please specify*:**

- ☐ HIV / AIDS
- ☐ STD (Sexually Transmitted Disease)
- ☐ Cold sores
- ☐ Other: _____

YES NO DK Do you have any other problem, disease or condition not listed above?

***If yes, please specify*:**

_____

_____

_____

_____

_____

_____

FEMALES ONLY:

YES NO DK Are you or could you be pregnant? If yes, number of weeks _____ and due date: _____

YES NO DK Are you nursing?

YES NO DK Are you taking any of the following? (Specify): **BIRTH CONTROL FERTILITY DRUGS HORMONE REPLACEMENT**

ALLERGIES TO DRUGS / LATEX / METALS OR FOODS:

YES NO DK **Are you allergic to or have you had a reaction to any of the following? Please specify the type of reaction?**

- ☐ Local anesthetics (Lidocaine / Epinephrine)
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Other antibiotics (Specify): _____
- ☐ Aspirin
- ☐ Advil (Ibuprofen)
- ☐ Tylenol (Acetaminophen)
- ☐ Codeine
- ☐ Opioids (hydrocodone / oxycodone)
- ☐ Chlorhexidine mouth rinse (Peridex / Periguard)
- ☐ Other Medication(s) (Specify): _____
- ☐ Latex (rubber)
- ☐ Metals / Jewelry (nickel / chrome)
- ☐ Dietary allergies

Type of reaction(s) to above: _____

MEDICATIONS:

YES NO DK **Are you taking, or are you supposed to be taking any medications – prescription, over the counter, dietary supplements, herbal medicine or vitamins? If yes, please list below:**

Medications or Supplements: Prescription, over the counter, dietary supplement, herbal medicines and vitamins	**Dose** (mg)	**How Often?** (1x/day, etc)	**Reason for Use:**	**Date Started:**

Dr. Andrew Shelby, DMD, MS
4505 W 6th St. Suite B, Lawrence, KS 66049

MEDICAL HISTORY FORM

REASON FOR VISIT:

What is the reason for your dental visit today? **EXAMINATION** **EMERGENCY** **CONSULTATION** **PROCEDURE**
Specify: _____

PAST DENTAL TREATMENT:

YES NO DK Have you been to the dentist before?
If yes, how long ago was your last dental exam? **0-6 MONTHS** **6-12 MONTHS** **1-2 YEARS** **>2 YEARS**
If yes, how long ago was your last dental x-rays? **0-6 MONTHS** **6-12 MONTHS** **1-2 YEARS** **>2 YEARS**
If yes, how long ago was your last dental cleaning? **0-6 MONTHS** **6-12 MONTHS** **1-2 YEARS** **>2 YEARS**

YES NO DK Do you have a history of tooth extractions or oral surgery?
(Specify): **EXTRACTIONS** **IMPLANTS** **JAW SURGERY** **TMJ SURGERY** **TRAUMA**

YES NO DK Have you had any periodontal (gum) treatments? (Specify): **DEEP CLEANING** **SURGERY**

YES NO DK Do you have bridges or wear dentures or partials? (Specify): **BRIDGES** **DENTURES** **PARTIALS**

YES NO DK Have you ever had root canal treatment?

YES NO DK Have you ever had orthodontics (braces) treatment?

YES NO DK Have you had a local anesthetic (Lidocaine) for dental purposes?
If yes, have you experienced any problems? (needle anxiety, hard to get numb, etc.)

YES NO DK Have you had any problems associated with previous dental treatment?

YES NO DK Has fear ever prevented you from seeking dental care?

DENTAL PROBLEMS (SIGNS / SYMPTOMS):

YES NO DK Are you currently experiencing dental pain or discomfort?
If yes, is it causing headaches, earaches or neck pains? (Specify): **HEADACHES** **EARACHES** **NECK PAINS**

YES NO DK Are your teeth sensitive to cold, hot, sweets or pressure? (Specify): **COLD** **HOT** **SWEETS** **PRESSURE**

YES NO DK Do you have problems with eating? (Specify): **TROUBLE CHEWING** **SWALLOWING** **VOMITING** **OTHER**

YES NO DK Do you have swelling in or around you mouth, face or neck? (Specify) **MOUTH** **FACE** **NECK**

YES NO DK Do you have loose teeth?

YES NO DK Do you have any clicking, popping, discomfort, or limited opening in the jaw?
(Specify): **CLICKING** **POPPING** **DISCOMFORT** **LIMITED OPENING**

YES NO DK Do you have or have you had sores or ulcers in your mouth? If yes, location: _____

YES NO DK Have you ever injured your face, jaws or teeth?

YES NO DK Are you unhappy with your smile or the appearance of your teeth?

YES NO DK Do you have a bad taste or bad breath? (Specify): **BAD TASTE** **BAD BREATH**

YES NO DK Do you experience dry mouth?

DENTAL DISEASE PREVENTION (ORAL HYGIENE):

How often and when do you brush your teeth? **NEVER** **SOMETIMES** **1x/WEEK** **1x/DAY AM** **1x/DAY PM** **2x/DAY** **>2x/DAY**
How often do you floss you teeth? **NEVER** **SOMETIMES** **1x/WEEK** **1x/DAY AM** **1x/DAY PM** **2x/DAY** **>2x/DAY**
Do your gums bleed when you brush of floss? **NEVER** **SOMETIMES** **1x/WEEK** **1x/DAY AM** **1x/DAY PM** **2x/DAY** **>2x/DAY**