Health History

McGonigle Dental Associates
17519 80th Avenue • Tinley Park, IL 60477 • www.mcgonigledental.com • (708) 429-2111

The personal information and medical history requested below is to enable McGonigle Dental Associates to aid in evaluating your dental health thoroughly and completely. It is important for you to give us complete and accurate answers so that we may give you personal attention. This will become part of your dental record and will be held in strict confidence. Thank You.

PERSONAL INFORMATION Date: _____ DOB: _____

Patient Name: _____

HEALTH HISTORY (please circle Yes or No or answer the question in space provided)

Are you under the care of a physician? . . . . . Yes No
For what reason? _____
_____
Name of your physician? _____
Have you had a major surgery? . . . . . Yes No
When? _____
For what? _____
Pre-Medicate? . . . . . Yes No
Have you been in the hospital recently? . . . . . Yes No
When? _____
For what? _____
_____
Do your gums bleed? . . . . . Yes No
Do you have difficulty chewing your food? . . . . . Yes No
Have you ever worn braces on your teeth? . . . . . Yes No
Are you having any discomfort or pain from:
Your mouth or face now? . . . . . Yes No
Lately? . . . . . Yes No
If so, please describe: _____
_____
_____
Are you aware of any dental needs now? . . . . . Yes No
If so, please describe: _____
_____
_____
Are you pregnant now? . . . . . Yes No
How many weeks? _____

PLEASE LIST ALL MEDICATIONS (and what you take them for)
(PRESCRIPTION, NATURAL & OVER-THE-COUNTER)

_____
_____
_____
_____

PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING

Allergens (please write in allergies if not listed below)

- ☐ Penicillin Allergy
- ☐ Amoxicillin Allergy
- ☐ Ampicillin Allergy
- ☐ Augmentin Allergy
- ☐ Keflex Allergy
- ☐ Aspirin Allergy
- ☐ Benadryl Allergy
- ☐ Clindamycin Allergy
- ☐ Ibuprofen Allergy
- ☐ Tetracycline Allergy
- ☐ Codeine Allergy
- ☐ Erythromycin Allergy
- ☐ Morphine Allergy
- ☐ Vaseline Allergy
- ☐ Vicodin Allergy
- ☐ Latex Allergy
- ☐ Sulfa Allergy
- ☐ Other _____

PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING (continued)

- ☐ Heart Valve Replacement Year _____
- ☐ Cardiac Stent Placement Year _____
- ☐ History of Infective Endocarditis
- ☐ Congenital Heart Defects (CHD)
- ☐ Atrial Fibrillation (A Fib)
- ☐ Congestive Heart Failure (CHF)
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Heart Attack / Year _____
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Adverse Reactions to Anesthetic (i.e. Epinephrine)
- ☐ Stroke / Year _____
- ☐ Bleeding Problems/Blood Thinner Use (i.e. Coumadin, Warfarin)
- ☐ Anemia
- ☐ Joint Replacement / Year _____
- ☐ Lung Trouble, Emphysema, Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Additional Oxygen Requirement
- ☐ Adverse Reaction to Nitrous Oxide (Laughing Gas)
- ☐ Tuberculosis
- ☐ Chronic Cough
- ☐ Asthma
- ☐ Additional Oxygen Requirement
- ☐ Sinus Problems
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Dialysis Treatment
- ☐ Hepatitis, Specific Type: __A, __B, or __C
- ☐ HPV (Human Papilloma Virus)
- ☐ HIV/AIDs
- ☐ Thyroid Conditions
- ☐ Epilepsy/Seizures
- ☐ Dizziness/Fall Risk
- ☐ Hearing or Sight Impaired
- ☐ Dental Anxiety
- ☐ Sensory Processing Disorder
- ☐ Spectrum Disorder (i.e. Autism, Asperger's)
- ☐ Psychiatric Treatment
- ☐ Arthritis, Gout
- ☐ Osteoporosis
  - ☐ Have you ever taken/ or currently take Bisphosphonates?
  - ☐ Have you taken Boniva, Reclast, Fosamax or Actonel?
- ☐ Cancer
  Cancer Type (Leukemia/Tumor, i.e.)
  _____
  Currently in Treatment/History Year _____
- ☐ Radiation Treatment to Head/Neck Area
- ☐ Oral Ulcers
- ☐ Unexplained Weight Loss
- ☐ Recent Travel Outside of the U.S.
- ☐ Tobacco Use
- ☐ Recreational Drug Use

☐ Other (please explain) _____
_____
_____
_____
_____
_____
_____
_____

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Sleep Concerns: Am I at Risk for Sleep Apnea? (please circle Yes or No or answer the question in space provided)

Have you noticed or has your bed partner witnessed any episodes of gasping or choking during your sleep? . . . . . Yes No

Has your bed partner witnessed you stop breathing? . . Yes No

Do you prefer to sleep sitting upright? . . . . . Yes No

Do you wake frequently to use the bathroom? . . . . . Yes No

Do you snore when you sleep on your side? . . . . . Yes No

Do you snore in all sleep positions? . . . . . Yes No

Have you had a recent increase in weight? . . . . . Yes No

Explain:

_____

_____

_____

_____

_____

_____

_____

_____

What have you liked the most about any dental office you have been to?

_____

_____

What have you liked the least?

_____

_____

Are you happy with your smile?

_____

_____

Have you ever had any illness or complications associated with any previous dental treatment?

_____

_____

Have you ever had a frightening experience with dentistry?

_____

_____

_____

_____

_____

If there is any information of any kind which you feel would be of value to us in any way, please add such information here:

_____

_____

_____

_____

_____

Thank you for your cooperation.

PLEASE SIGN BELOW

Signature: _____ **Date:** _____

Print Name: _____

Guarantor Signature (if patient under age 18)

Signature: _____ Date: _____

Print Name: _____

Relationship: _____