Sonja L Maggard, DMD
Family, Cosmetic, & Implant Dentistry

121 Prosperous Place, Suite 12B
Lexington, KY 40509
(859) 263-1888

Patient Health History

Today's Date:____/____/_____

Patient Name _____
Last First Initial

Reason for today's visit:_____
Former Dentist:_____
Date of last dental visit:____/____/_____ Date of last dental x-rays:____/____/_____

Dental History: (Please circle all that apply)

TMJ
Headaches
Grinding/Clenching Teeth
Clicking or Popping of Jaw
Pain or Discomfort in Jaw Joint
Pain or Discomfort around Ear

Perio
Periodontal Disease (gum)
Bleeding Gums
Swollen Gums
Bad Breath
Dry Mouth
Mouth Breathing

Habits
Cigarette, Pipe, Cigar Smoking
Chewing Tobacco
Fingernail Biting

Pathology
Tooth Pain
Loose Teeth
Broken Fillings
Food Collection between Teeth
Chewing on one side of Mouth
Burning sensation of Tongue
Sores/Growths in Mouth
Blisters on Lips or Mouth
Lip or Cheek Biting
Sensitivity to Heat
Sensitivity to Cold
Sensitivity to Sweets
Sensitivity when Biting

Oral Hygiene
Problems with previous dental work
How often do you brush_____
How often do you floss_____
Type of bristles: Hard Medium Soft
Orthodontic Treatment
I like my smile
I dislike my smile

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Past Medical History: (Please circle all that apply)

Anemia	Coronary Artery Disease	Hyperthyroidism
Anxiety	Cortisone Treatments	Hypothyroidism
Arthritis	Cough (persistent/bloody)	Kidney Disease
Artificial Joints	Depression	Leukemia
Asthma	Diabetes	Liver Disease
Atrial Fibrillation	End-Stage Renal Disease	Low Blood Pressure
Back Problems	Epilepsy	Nervous Problems
Bleeding Abnormally	Fainting or Dizziness	Pacemaker
(with extractions or surgery)	GERD	Psychiatric Care
Blood Disease	Headaches	Radiation Therapy
Cancer	Heart Murmur	Respiratory Disease
Type_____	Heart Problems	Seizures
Chemical Dependency	Hearing Loss	Skin Cancer
Chemotherapy	Hepatitis	Stroke
Circulatory Problems	Herpes	Tuberculosis (TB)
Congenital Heart Lesions	High Blood Pressure	Other_____
COPD	HIV/AIDS	

Cautions: (Please circle Yes or No)

Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No
Do you have an artificial heart valve?	Yes	No
Do you require antibiotics prior to dental procedures?	Yes	No
Do you have an allergy to red dye	Yes	No
Do you have an allergy to topical antibiotic ointments?	Yes	No
Are you taking blood thinners?	Yes	No
Are you pregnant, or currently trying to get pregnant?	Yes	No
Do you have an allergy to lidocaine?	Yes	No
Do you experience rapid heartbeat with epinephrine?	Yes	No
Do you get yeast infections with antibiotics?	Yes	No
Have you ever had problems with excessive bleeding?	Yes	No

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Do you have problems with healing? Yes No

Do you have an allergy to Latex? Yes No

Have you had an artificial joint replacement? Yes No

If yes, when and what body locations?_____

Medications: (Please list all medications you are taking, and what they are for)

_____
_____
_____
_____

Allergies: (Please circle all that apply)

Aspirin	Codeine
Barbiturates (sleeping pills)	Iodine
Local Anesthesia	Latex
Penicillin	No Allergies
Sulfa	Other_____

Pharmacy of Choice:_____
Pharmacy Phone:_____
Pharmacy Location:_____

Patient Comments:_____
_____

Doctor Comments:_____
_____
_____

I certify that all medical information listed above is honest and accurate to the best of my knowledge.

*Patient/Guardian Signature:*_____ *Date:*____/____/_____

I, Dr. Sonja Maggard, have reviewed the above medical/dental history of said patient.

*Doctor Signature:*_____ *Date:*____/____/_____