Tennessee Family Dental

Dental and Medical History

Disclaimer

Dentists treat the area in and around your mouth, however, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could play an important role in the dentistry you will receive at our office. Thank you in advance.

Sleep Apnea and Your Dentist...

The following questions are related to your night-time breathing habits. Obstructive Sleep Apnea is a serious medical condition that affects 1 out of 4 people and can cause snoring, diabetes, high blood pressure, poor memory, daytime fatigue and even death.
This condition can be treated by an oral appliance made by a Tennessee Family Dental dentist AND may be covered by medical insurance.

Have you ever had a sleep study? ◯ Yes ◯ No

Have you ever been diagnosed with Sleep Apnea? ◯ Yes ◯ No

If "Yes" to the above question, do you currently wear a CPAP? ◯ Yes ◯ No

Has anyone ever told you that you snore loudly? ◯ Yes ◯ No

Do you feel excessively fatigued during the day? ◯ Yes ◯ No

Would you like information about a home sleep study to determine if you suffer from sleep apnea? ◯ Yes ◯ No

Dental Questions

When was your last cleaning?

☐ 6 months ☐ 1-2 years ago ☐ 2-5 years ago ☐ Way too long ago :)

What concerns you most about your teeth?

☐ My teeth are too dark.
☐ I would like information on whitening.
☐ My teeth are crooked.
☐ I would like information on Invisalign.
☐ My gums occassionally bleed.
☐ I would like information on gum therapy.
☐ Some of my teeth are missing.
☐ I would like information on implants.

What are your least favorite parts about going to the dentist?

☐ X-rays
☐ Too expensive
☐ Anesthetic (The "shot")
☐ I'm afraid it will hurt
☐ Dental Cleaning
☐ Too time consuming
☐ Noise of the drill
☐ Everything

Medical Questions

Are you under a physician's care now? ◯ Yes ◯ No If yes

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes

Do you use tobacco? If "Yes", how often? ◯ Yes ◯ No If yes

Are you on a special diet? ◯ Yes ◯ No If yes

Are you allergic to any of the following?

☐ Aspirin
☐ Latex
☐ Penicillin
☐ Sulfa Drugs
☐ Codeine
☐ Local Anesthetics
☐ Metal
☐ The Dentist

Other? ☐ If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia or Anemia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Herpes	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Sleep Apnea	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:___________