www.GriecoDentistry.com
724-327-4130

GriecoDentistry™
healthy smiles. naturally.

3894 Old William Penn Highway
Murrysville, PA 15668

Patient Medical and Dental History

Patient Name: _____ ***Today's Date:*** ___/___/___

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Physician: _____ **Phone:** _____ **Last Exam Date:** ___/___/___

Previous Dentist: _____ **X-Rays:** _____ **Last Exam Date:** ___/___/___

Are you currently under medical treatment? ☐ Yes ☐ No **If Yes, please explain:** _____

Please explain any surgery or serious illness you have had in the last 5 years: _____

Please list any medications that you are taking, including non-prescription medications, herbs, vitamins, and oral contraceptives:

Medication	*Dosage*	*Reason*

Please list any medications that you are allergic to, or have had a reaction to: _____

Are you allergic to Latex? ☐ Yes ☐ No **Do you use tobacco?** ☐ Yes ☐ No

WOMEN: Are you preganant or think you may be pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Please check any of the following conditions that you have, or have had in the past:

- ☐ High Blood Pressue
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Angina
- ☐ Chest Pains
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Heart Murmur*
- ☐ Mitral Valve Prolapse*
- ☐ Cardiac Pacemaker
- ☐ Stroke
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Easily Winded
- ☐ Frequently Tired
- ☐ Anemia
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Thyroid Problem
- ☐ HIV/AIDS
- ☐ Epilepsy/Convulsions
- ☐ Fainting/Seizures
- ☐ Cancer or Leukemia
- ☐ Radiation Therapy
- ☐ Hepatitis/Jaundice
- ☐ Liver Disease
- ☐ Stomach Ulcers
- ☐ Glaucoma
- ☐ Recent Weight loss
- ☐ Arthritis
- ☐ Joint Replacement*
- ☐ Joint Implant*
- ☐ Swollen Ankles
- ☐ Bleeding or Clotting Problems
- ☐ Artificial Stents or Shunts

**If you have any of the conditions with an asterisk (*), please contact our office prior to your appointment, as you may require Pre-Medication.*

Reason for today's visit: _____

Please circle Yes (Y) or No (N) in response to the following:

- **Y N** Is fluoride taken in any form?
- **Y N** Bad breath?
- **Y N** Brush daily?
- **Y N** Floss daily?
- **Y N** Headaches, ear aches, or neck pain?
- **Y N** Gums bleed when you brush?
- **Y N** Facial pain?
- **Y N** Periodontal gum treatments?
- **Y N** Orthodontic (braces) treatment?
- **Y N** Clicking or popping in jaw joints?
- **Y N** Removable dental appliances?
- **Y N** Injuries to teeth or jaw? If Yes, please explain _____
- **Y N** For your child, any mouth habits? (thumb sucking, pacifier, nail biting, etc.)

Have you had a serious/difficult problem associated with any previous dental treatment? ☐ Yes ☐ No

If Yes, please explain: _____

How would you describe your current dental health? _____

How do you feel about your teeth's appearance? _____

Would you like to hear about ways we can improve the look of your smile? ☐ Yes ☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient** (or parent if minor):* _____ ***Date: ___/___/___