High Desert Dental – Joshua M. Eastham, DMD
132 Walnut Avenue, Ste. F, Grand Junction, CO 81501 (970) 245-1758

Patient Name: _____ **Date:** _____

Primary reason for this dental appointment: ___Examination ___Emergency ___Consultation

Dental History **Please Circle**

Do you have a specific dental problem? Describe _____ Yes No

Do you have dental examinations on a routine basis? Date of last visit _____ Yes No

Do you think you have active decay or gum disease? _____ Yes No

Do you brush and floss on a routine basis? _____ Yes No

Do you like your smile? _____ Yes No

Does food catch between your teeth? _____ Yes No

Do you have any loose teeth? _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping, or discomfort in the jaw joint? _____ Yes No

Do you grind your teeth? _____ Yes No

Do you smoke or chew? _____ Yes No

Do you have any sores or growths in your mouth? Describe _____ Yes No

Medical History

Are you under a physician's care now? If yes, why? _____ Yes No

Who is the physician? _____ Phone # _____

Have you ever been hospitalized or had a major operation? Describe _____ Yes No

Have you ever had a serious injury to your head or neck? Describe _____ Yes No

Are you on a special diet? Describe _____ Yes No

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? List _____ Yes No

_____

Are you taking blood thinners? _____ Yes No

Are you allergic to any medications or substances? If yes, please check item below:

____Aspirin ____Penicillin ____Codeine ____Acrylic ____Metal ____Milk ____Other

Women: (please check) ___Pregnant/trying to get pregnant ____Nursing ____Taking oral contraceptives

Do you now or have ever had any of the following? Please check all that apply. If you answer "yes" to any of the conditions, please call prior to your appointment as premedication or changes in medication may be required.

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
AIDS			Fainting /Dizziness			Osteoporosis		
Medicine Allergies			Frequent Cough			Pain in Jaw Joints		
Pollen/Dust Allergies			Frequent Diarrhea			Parathyroid Disease		
Alzheimer's Disease			Genital Herpes			Protease Inhibitor		
Anemia			Glaucoma			Psychiatric care		
Angina/Chest Pain			Hay Fever			Pulmonary Shunt		
Aredia I.V. Reciast I.V			Heart Attack			Recent Blood Transfusion		
Artificial Heath Valve			Heart Disease/ Surgery			Recent Weight Loss		
Artificial joint			Heart Murmur or Defect			Renal Dialysis		
Asthma			Heart Pace Maker			Rheumatic Fever		
Arthritis/Gout			Hemophilia			Rheumatism		
Bacterial Endocarditis			Hepatitis A			Scarlet Fever		
Bisphosphonates			Hepatitis B or C			Shortness of Breath		
Bloody Sputum			Herpes			Sexually Transmitted Disease		
Breathing Problems			High Blood Pressure			Sickle Cell Disease		
Bruise Easily/ Blood Disease			HIV Positive			Sinus Trouble		
Cancer			Hives or Rash			Sleep Apnea		
Chemotherapy			Hypoglycemia			Stomach/Intestinal Disease		
Cold Sores			Irregular Heart Beat			Stroke		
Cochlear Implants			Kidney Problems			Swelling of Limbs		
Congenital Heart Disorder			Leukemia			Tattoos/Body Piercing		
Coronary Stent			Liver Disease			Thyroid Disease		
Cortisone Medicine			Low Blood Pressure			Tuberculosis		
Diabetes			Lung Disease			Tumors or Growths		
Drug Addition/Alcoholism			Methemoglobinemia			Ulcers		
Emphysema			Mitral Valve Prolapse			Unexplained Fever		
Epilepsy or Seizures			Need Premedication			X ray Treatment (Radiation)		
Excessive Bleeding			Nervousness			Yellow Jaundice		
Excessive Thirst			Night Sweats			Zometo L.V.		
Fosamax, Actonel, Boniva			Osteonecrosis of Jaw					

Have you ever had any other serious Illness not checked above? Describe _____Yes No

Do you wish to talk to the dentist Privately about any problem? _____Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist and staff at the next appointment without fail.

X_____ **Date:** _____

Patient Signature (parent or guardian)

Reviewed by Doctor_____ **Date:** _____

History Review and Significant Findings_____

_____

Medical Updates:

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	**Exceptions**	**No Change**	**Patient's Signature**	**Reviewed by:**
_____	_____	_____	_____	**Dr.**_____
_____	_____	_____	_____	**Dr.**_____
_____	_____	_____	_____	**Dr.**_____