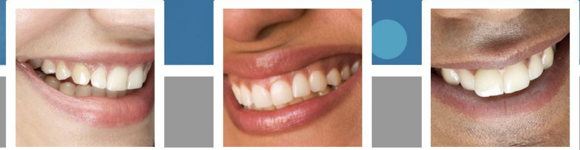
Downing Street Dental
2121 South Downing Street
Denver, CO 80210

(303)733-8885

office@downingstreetdental.com
downingstreetdental.com



# MEDICAL HISTORY

Please rate the health of your mouth.

☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

Have you had your wisdom teeth extracted?

◯ Yes ◯ No

Do you like the appearance of your smile? If no, what would you change?

* ☐ Yes ☐ No ☐ Whiter Smile ☐ Straighter Smile

Do your gums bleed when brushing/ flossing?

◯ Yes ◯ No

Do you clench or grind your teeth?

◯ Yes ◯ No

Please rate your anxiety level with dental treatment

◯ None ◯ Slight ◯ Moderate ◯ High ◯ Very High

Please list concerns you have with the health of your mouth, teeth, gum tissue, or sensitivity?

When was your last dental visit?

Are you currently under the care of a physician?

◯ Yes ◯ No

For what?

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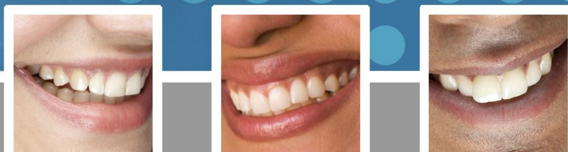

Have you ever been told you need a Pre-Med before dental appointments?

◯ Yes ◯ No

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Have you ever been diagnosed with the Hepatitis virus? If so, what type?

◯ A ◯ B ◯ C

Do you have a history of tobacco/ marijuana use?

☐ Cigars ☐ Chewing tobacco ☐ Cigarettes ☐ Marijauna

Are you pregnant or nursing?

◯ Yes ◯ No

Please check the following that apply to family history.

☐ Heart disease ☐ Diabetes ☐ Gum Disease

**Please check all that apply to you**

| | | |
|---|---|---|
| ☐ AIDS | ☐ Alcohol/Drug Abuse | ☐ Allergies |
| ☐ Allergy  Clindamycin | ☐ Allergy to Ceclore | ☐ Allergy to Keflex |
| ☐ Allergy to Zithromax | ☐ Allergy/Anesthetic | ☐ Anemia |
| ☐ Anxiety | ☐ Arthritis | ☐ Artificial Joints |
| ☐ Asthma | ☐ Blood Disease | ☐ Cancer |
| ☐ Chemotherapy Tx | ☐ Codeine Allergy | ☐ Depression |
| ☐ Diabetes | ☐ Dizziness | ☐ Emphysema |
| ☐ Epilepsy | ☐ Excessive Bleeding | ☐ Fainting |
| ☐ Glaucoma | ☐ Growths | ☐ Hay Fever |
| ☐ Head Injuries | ☐ Heart Disease | ☐ Heart Murmur |
| ☐ Hepatitis | ☐ High Blood Pressure | ☐ High Cholesterol |
| ☐ HIV | ☐ Jaundice | ☐ Kidney Disease |

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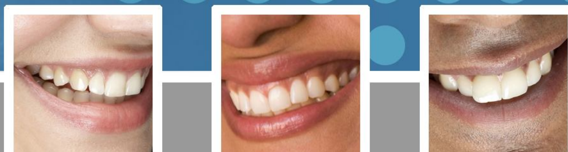

- [ ] LATEX ALLERGY
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Mitral Valve
- [ ] Morphine allergy
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] PRE MED
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Thyroid Disease
- [ ] Tobacco Use
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Please list any other allergies you have.

Please list all medications and supplements you are currently taking, prescribed or non prescribed.
(If you have a written list you can give it to the receptionist and she will copy it for you.)

Todays Blood Pressure

- [ ] By checking this box I acknowledge that all information reported is up to date, accurate, and to the best of my knowledge.

Signature: ______________________

Date:

Response Date: