Dr. Pamela M. Lilly Dr. Meagan Lilly-Frank 406.862.8180

Lilly Family Dentistry

Initial Patient Assessment

Patient Name:_____Date:_____
Last First MI

What is your Chief Complaint?_____

_____

Dental History

How often do you visit the dentist?_____ Type of care received:_____

When was the last time you had dental x-rays taken?_____

Have you experienced any oral-facial injuries?_____
(Date, cause, type of injury)

Have you experienced any difficulties with past treatments?_____

Do you have any allergies or sensitivities to:
☐ Local Anesthetics ☐ Latex Gloves ☐ Rubber Dam ☐ Dental Material _____

Do you have TMJD (Temporomandibular Joint Dysfunction)?_____

Do you experience pain in your jaw when chewing? _____

Medical History

Weight:_____ Height _____

Do you have any drug allergies or other adverse drug effects?_____

Are you taking any medications, vitamins, supplements? ☐ Yes ☐ No
Describe:_____

Date examined by physician?_____ For what purpose?_____

Physician's Name:_____Phone:_____

Past and present illness?_____
_____

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History of hospitalizations (when, why)?_____

_____

Do you snore? ☐ Yes ☐ No Do you have sleep apnea? ☐ Yes ☐ No Had a sleep study? ☐ Yes ☐ No

For Women Only:

Are you pregnant?	☐ Yes ☐ No	Noticed change in menstrual pattern	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No	Are you taking oral contraceptives?	☐ Yes ☐ No

Family History (diabetes, high blood pressure, heart disease, seizures, bleeding, cancer, other)

_____

_____

Social History (tobacco, alcohol, recreational drugs [type, amount, frequency])

_____

Have you ever or do you now have any of the conditions listed?

Skin

Itching, rash	☐ Yes ☐ No	Piercings, tattoos	☐ Yes ☐ No	Lack of body hair	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Pigmentations	☐ Yes ☐ No	Loss of body hair	☐ Yes ☐ No

Extremities

Varicose veins	☐ Yes ☐ No	Muscle weakness, pain	☐ Yes ☐ No	Bone deformity	☐ Yes ☐ No
Swollen, painful joints	☐ Yes ☐ No	Prosthetic joints	☐ Yes ☐ No	Bone fractures	☐ Yes ☐ No

Eyes

Conjunctivitis	☐ Yes ☐ No	Double vision	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Blurring of vision	☐ Yes ☐ No	Drooping of eyelid	☐ Yes ☐ No		

Ear, Nose, Throat

Earache	☐ Yes ☐ No	Nosebleeds	☐ Yes ☐ No	Sore throat	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No	Sinusitis	☐ Yes ☐ No	Hoarseness	☐ Yes ☐ No

Respiratory

Shortness of breath	☐ Yes ☐ No	Blood in sputum	☐ Yes ☐ No	Wheezing, asthma	☐ Yes ☐ No
Cough	☐ Yes ☐ No	Bronchitis, emphysema	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Cardiac

High/low blood pressure	☐ Yes ☐ No	Pain, pressure in chest	☐ Yes ☐ No	Rheumatic, scarlet fever	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No

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Gastrointestinal (Stomach/Intestines)

Difficulty chewing	☐ Yes ☐ No	Eating disturbances	☐ Yes ☐ No	Jaundice, hepatitis	☐ Yes ☐ No
Difficulty swallowing	☐ Yes ☐ No	PUD, GERD	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No

Genitourinary

Difficult urination	☐ Yes ☐ No	Excessive urination	☐ Yes ☐ No	Sexually transmitted disease	☐ Yes ☐ No
Painful urination	☐ Yes ☐ No	Blood in urine	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No

Endocrine (Hormones)

Thyroid trouble	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Weight change	☐ Yes ☐ No	Excessive thirst	☐ Yes ☐ No

Hematopoietic (Blood, Immunity)

Easily bruise	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Excessive bleeding	☐ Yes ☐ No	HIV, AIDS	☐ Yes ☐ No	Spleen problems	☐ Yes ☐ No

Neurological

Headaches	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Neuralgia	☐ Yes ☐ No
Dizziness, fainting	☐ Yes ☐ No	Paresthesia	☐ Yes ☐ No	Paralysis	☐ Yes ☐ No

Psychiatric

Anxiety	☐ Yes ☐ No	Other_____	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Other_____	☐ Yes ☐ No

Growth or Tumor

Surgery	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
Radiotherapy	☐ Yes ☐ No	Other_____	☐ Yes ☐ No

Have you ever had any serious illness not checked above? If yes, describe:_____

I certify that any and all questions I had about the inquiries above have been answered to my satisfaction. I was asked all of the questions on this form and I have answered these questions truthfully and completely. I will not hold Pamela M. Lilly, DDS, PC (Lilly Family Dentistry) responsible for any errors or commissions that I may have made. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature:_____Date:_____

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