LANCASTER SMILES
Dr Michael E. Funk DMD
2359 Oregon Pike, Suite 102
Lancaster, PA 17601
www.lancastersmilespc.com
717-394-3592

Medical History Form

Patient Information

Patient Name: _____ Date of Birth: _____/_____/_____

Primary Care Physician: _____ Phone Number: ( )_____-_____

Preferred Pharmacy: _____ Phone Number: ( )_____-_____

Current Health Status

How would you describe your overall health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor
Have you been hospitalized within the last 5 years?
☐ No ☐ Yes (Explain): _____
Have you had surgery within the last 5 years?
☐ No ☐ Yes (Explain): _____
Are you currently under a physician's care?
☐ No ☐ Yes (Reason): _____
Have you ever tested positive for Covid-19? If yes, When: _____

Women Only

Are you pregnant?	Are you nursing?	Are you on Birth Control?
☐ No ☐ Yes ☐ Unsure	☐ No ☐ Yes	☐ No ☐ Yes

Tobacco, Alcohol, and Lifestyle

Do you currently smoke or use tobacco?
☐ No ☐ Yes Type: _____ How many per day? _____ How many Years? _____
Do you consume alcohol?
☐ No ☐ Yes How many drinks per week? _____
Do you use recreational drugs?
☐ No ☐ Yes Explain: _____

Allergies

☐ No known allergies ☐ Penicillin ☐ Latex ☐ Aspirin ☐ Ibuprofen ☐ Codeine ☐ Sulfa drugs ☐ Metal
☐ Local anesthetics ☐ Other: _____ Reaction: _____

Medical Conditions

Please check all that apply:

☐ Acid Reflux	☐ Chronic Pain	☐ Heart Pacemaker *	☐ Osteoporosis
☐ Allergies	☐ Depression	☐ Heart Surgery *	☐ Radiation Therapy
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Sickle Cell Disease
☐ Angina	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Sinus Problems
☐ Anxiety	☐ Fainting or Dizziness	☐ High Blood Pressure	☐ Sleep Apnea
☐ Arthritis	☐ Frequent Cough	☐ HIV / AIDS *	☐ Stroke
☐ Artificial Heart Valves *	☐ Glaucoma	☐ Infectious Disease	☐ Surgical Shunt*
☐ Asthma	☐ Headaches/Migraines	☐ Joint Replacement	☐ Thyroid Disorder
☐ Autoimmune Disease	☐ Heart Attack	☐ Kidney Disease	☐ TMJ Disorder
☐ Breathing Problems	☐ Heart Disease	☐ Liver Disease	☐ Tuberculosis
☐ Bleeding Disorder	☐ Heart Disorder (Congenital)*	☐ Lung Disease	☐ Other:_____
☐ Cancer	☐ Heart Infection *	☐ Mental Disorders	_____
☐ Chemotherapy	☐ Heart Murmur *	☐ Mitral Valve Prolapse*	_____

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Medications

Please list all medications, vitamins, supplements, and injections:

Medication	Dose	Frequency

Patient Certification

I certify that the information provided is accurate and complete to the best of my knowledge.

Patient Signature: _____

Date: _____

Dental History

Previous Dental Care

Former Dentist: _____ Date of Last Dental Visit: _____

Date of Last Dental Cleaning: _____ Date of Last Dental X-rays: _____

How often do you receive dental care?

☐ Every 3–4 months ☐ Every 6 months ☐ Only when needed ☐ Rarely

Current Dental Concerns

What brings you to our office today?

_____

Are you currently experiencing:

☐ Bad breath	☐ Difficulty chewing	☐ Missing teeth	☐ Tooth pain
☐ Bleeding gum	☐ Grinding/clenching	☐ Sensitivity when chewing	☐ None
☐ Broken tooth	☐ Headaches	☐ Sensitivity to cold	
☐ Clicking/popping jaw	☐ Jaw pain	☐ Sensitivity to hot	
☐ Cosmetic concerns	☐ Loose tooth	☐ Swelling	

Oral Hygiene Habits

How often do you brush?

☐ Once daily ☐ Less than once daily ☐ Twice daily ☐ More than twice daily

How often do you floss or clean between teeth?

☐ Daily ☐ Several times per week ☐ Occasionally ☐ Never

Do you use: (please choose all that apply)

☐ Water flosser ☐ Electric toothbrush ☐ Mouth rinse ☐ Fluoride products

Previous Dental Experiences

Have you ever had:

☐ Bite splint/night guard	☐ Gum treatment	☐ Orthodontics/Invisalign	☐ TMJ treatment
☐ Dental implants	☐ Oral surgery	☐ Root canal treatment	

Have you ever had a negative dental experience?

☐ No ☐ Yes (Please explain)

_____

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Dental History Form Continued

Sleep and Airway

Do you snore? ☐ No ☐ Yes

Have you been diagnosed with sleep apnea? ☐ No ☐ Yes

Do you often wake feeling tired? ☐ No ☐ Yes

Dental History Goals

What would you most like to improve regarding your oral health or smile?

_____

_____

Dental Health Wants, Needs & Expectations Form

We want to understand what is important to you so we can provide care that aligns with your goals and values.

Why Did You Choose Our Office?

_____

What Is Most Important To You?

_____

_____

Please rank the following:

	Very Important	Somewhat Important	Not Important
Healthy teeth for life	☐	☐	☐
Avoiding tooth loss	☐	☐	☐
Comfortable chewing	☐	☐	☐
Attractive smile	☐	☐	☐
Fresh breath	☐	☐	☐
Avoiding dental problems	☐	☐	☐
Minimizing treatment time	☐	☐	☐
Long-lasting dentistry	☐	☐	☐

Smile Concerns

What concerns do you have about your smile?

☐Chipped teeth ☐Crooked teeth ☐Gaps ☐Missing teeth ☐Tooth color ☐Worn teeth ☐Uneven gums ☐No concern

Functional Concerns

Do you have difficulty with:

☐Biting ☐Chewing ☐Food trapping ☐Grinding/clenching ☐Jaw discomfort ☐Tooth wear ☐None

Future Vision

If we could accomplish one thing for your oral health over the next year, what would you want it to be?

Treatment Preferences

When discussing treatment, I prefer:

☐ The most comprehensive solution ☐ The most conservative solution ☐ Several options with pros and cons

☐ Phased treatment over time ☐ Focus only on urgent needs

Investment in Health

How would you describe your approach to healthcare and dental care?

☐ I prefer prevention and early treatment. ☐ I prefer to address problems as they occur.

☐ I want to preserve my teeth for life. ☐ I am primarily concerned with comfort and function.

☐ I am primarily concerned with appearance.

Final Question

What else would you like our team to know about you, your goals, or previous dental experiences?

_____

Patient Signature: _____

Date: _____