

PATIENT'S DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Date of Last X-rays _____ Last Visit _____

Reasons for Changing Dentists _____

How often do you brush? _____ How often do you floss? _____

What are your dental priorities? (ie: esthetics, dental health, financial) _____

Check if you have had any of the following:

- Bad Breathe
- Bleeding/Swollen Gums
- Clenching/Grinding Teeth
- Clicking/Popping Jaw
- Loose/Broken Teeth
- Sensitivity to Cold/Hots/Sweets
- Sores/Growths in Your Mouth

Please answer the questions below: (Y=Yes, N=No)

- Y N I like my smile.
- Y N I avoid brushing part of my mouth due to pain.
- Y N I have problems eating/chewing.
- Y N I have had facial/jaw injury.
- Y N I prefer tooth-colored fillings.
- Y N I want my teeth whiter.
- Y N I want my teeth straighter.

PATIENT'S MEDICAL HISTORY

Physician's Name _____ Phone Number _____ Last Visit _____

Check if you have had any of the following:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hepatitis, Type _____ | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Tumors/Malignancies |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependence | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune Suppressed | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

Please answer the questions below: (Y=Yes, N=No)

- Y N I smoke or use chewing tobacco. If yes, how many per day? _____ How many years? _____
- Y N I usually take an antibiotic prior to dental treatment.
- Y N I have taken "fen-phen" or drugs of that category (ie: Lonimin, Adipex, Fastin, Redux).
- Y N I have had major surgery. If yes, what type? _____ What year? _____
- Y N Are you pregnant/nursing? If yes, how many months? _____
- Y N Are you taking birth control pills?

MEDICATIONS

List medications you are currently taking:

ALLERGIES

- | | |
|---|--|
| <input type="checkbox"/> Aspirin/Ibuprofen | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Plastic/Acrylic |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Other (list below) | <input type="checkbox"/> Tetracycline |
- _____

"I have read and answered the above questions to the best of my knowledge."

Medical Health Reviewed By:

Signature of Patient/Parent or Guardian

Doctor's Signature

Date