PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, ect.)________________________

Previous Dentist ______________ Last Visit ________ Date of Last Cleaning ______________

Have you had any problems with past dental treatment? ________________________

Are you nervous about seeing a dentist? (Y) (N)

How often? ______________

How often do you brush? ________ Do you floss? (Y) (N)

(please circle each)

Y N I clench or grind my teeth during the day or while sleep.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.

Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straighter.
Y N I want my teeth whiter.

What are your dental priorities?________________________

(e.g.: appearance, dental health, financial considerations, etc)

PATIENT'S MEDICAL HISTORY

I consider my health to be (Please check one): ___Excellent ___Good ___ Fair ___ Poor

Do you have or have you had any of the following? Please circle Y for yes N for No.

1. Y N Heart disease
2. Y N Heart Murmur/Mital Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: Hip-Knee ____ Other ____________
16. Y N I smoke or use chewing tobacco. If yes, how much per day? How many years?
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery. Year ____ Type of operation __________ Year ____ Type of operation ____________
21. Y N Do you have any other medical problem or medial history NOT listed on this form?
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type ____
25. Y N Diabetes
26. Y N Excessive Urination
27. Y N Infectious Mononucleosis
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted Diseases
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation/Therapy
35. Y N History of Drug Addiction
36. Y N AIDS
37. Y N Immune Suppressed **Disorder**
38. Y N Hearing loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders
42. Y N Are you taking birth control?
43. Y N Are you could you be pregnant or nursing?

Are you allergic to any of the following?
Please circle Y for yes or N for no.

44. Y N Aspirin?Ibuprofen
45. Y N Sulfa Drugs/Sulfites/Sulfides
46. Y N Penicillin
47. Y N Codeine
48. Y N Latex, Metals, Plastics
49. Y N Local anesthetics (Novocaine)
50. Y N Other Medications Which ones? ____________

Please list all medications you are currently taking:

____

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____

Physician's Name ______________ Phone ____________

Address ______________ Fax ____________

In the event of an emergency, please contact

Name ____________________ Relationship ______________ Phone ____________

Name ____________________ Relationship ______________ Phone ____________

Medical health reviewed by:

X______________________ ___/___/___
Doctor's Signature Date

X______________________ ___/___/___
Patient's Signature Date

X______________________ ___/___/___
If Patient is a minor, Parent/Guardian Signature Date