



NAME

ADDRESS

PHONE #s HM: WK: CELL:

EMAIL SS # DOB

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Check all that apply:

- Are you under a physician's care now? Please explain:
- Medical doctors name & phone:
- Have you ever been hospitalized or had a major operation? Please explain:
- Have you ever had a serious head or neck injury? Please explain:
- Do you take, or have you taken, Phen-Fen, Adipex, or Redux? Please explain:
- List any medications you are taking:
- Do you use tobacco?
- Do you use controlled substances?

Women: Are You:

Pregnant/Trying to get pregnant? Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Erythromycin Metal Latex Local Anesthetics Tetracycline
- Other Please explain:

Do you have, or have you had, any of the following?

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> MRSA | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophillia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? If so, please explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

DENTAL HISTORY

When was your last dental visit?

When was your last dental cleaning?

Reason for todays visit

Do you have, or have you had, any of the following?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Pain When Biting | <input type="checkbox"/> Thumb Sucking |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Cold Sensitivity | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Nail Biting |
| <input type="checkbox"/> Burning Tongue | <input type="checkbox"/> Hot Sensitivity | <input type="checkbox"/> Snoring | |
| <input type="checkbox"/> Jaw Pain or Clicking | <input type="checkbox"/> Sweet Sensitivity | <input type="checkbox"/> Teeth Grinding | |

	Yes	No
Have you ever had treatment or been diagnosed with gum/periodontal disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any chips or stains on your teeth that concern you?	<input type="checkbox"/>	<input type="checkbox"/>

Is there anything you would like to change about your smile? Please explain:

What is your primary concern when scheduling dental treatment?

- | | |
|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Quality | <input type="checkbox"/> Discomfort |
| <input type="checkbox"/> Cost | <input type="checkbox"/> Time |

Special Note: _____

