Patient Dental Health

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

_____

_____

Previous Dentist: _____ **Date of Last Visit:** _____ **Last cleaning:** _____

Reason for Changing Dentist? _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ☐ Yes ☐ No If yes, please explain why? _____

How often do you brush? _____ **Do you floss? ☐ Yes ☐ No If yes, How often?** _____

(Please Circle Y for yes or N for no)

Y N Do you gag easily?
Y N Does food catch between your teeth?
Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I would like to improve my smile.
Y N I want whiter teeth.
Y N I avoid brushing part of my mouth due to pain.
Y N Do you wear dentures?
Y N Do you chew on only one side of your mouth?
Y N My gums feel tender of swollen.
Y N Do you have difficulty chewing food?
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.

Do you feel twings of pain when your teeth come in contact with:

Y N Hot foods or liquids?
Y N Sours?
Y N Cold foods or liquids?
Y N Sweets?
Y N Do you have any jaw symptoms at any time during the day or night?

What are your dental priorities? _____

Snoring? ☐ Yes ☐ No If so, please check all that apply?

☐ I snore, and/or I have been told that I snore
☐ I often feel tired during the day
☐ I stop breathing during sleep
☐ I have high blood pressure
☐ My body mass index is greater than 28
☐ I am over the age of 50

Patient Medical History

I consider my health to be (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you had any of the following? (Please Circle Y for yes or N for no)

Y N Heart Disease
Y N Heart Murmur/Mitral Valve Prolapse
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Pacemaker
Y N Stent
Y N Abnormal Blood Pressure
Y N Prolonged Bleeding Disorder
Y N Tuberculosis or Lung Disease
Y N History of Emotional or Nervous Disorder
Y N Liver Disease
Y N Jaundice
Y N Hepatitis Type ___
Y N Diabetes
Y N Ulcers
Y N Epilepsy/Seizures
Y N Herpes
Y N Anemia
Y N Kidney Disease
Y N Cancer/Chemotherapy
Y N History of Drug Addiction
Y N HIV
Y N AIDS
Y N Immune Suppressed Disorder
Y N Hearing Loss
Y N Fainting Spells
Y N Glaucoma
Y N Asthma
Y N Arthritis
Y N Tumor or Malignancy
Y N Radiation/Therapy
Y N Hay Fever

Patient Initials _____

Medical History Continued

Y N Sinus Trouble

Y N Infection Mononucleosis (Mono) **Women: Y N Are you taking birth control medication?**

Y N Excessive Urination and/or Thirst **Y N Are you or could you be pregnant or nursing?**

Y N Sexually Transmitted/Venereal Diseases

Y N Implants/Artificial Joints: Hip-Knee _____ Other _____

Y N I smoke or use chewing tobacco. If yes, how much per day? _____ How many years? _____

Y N I have consumed alcohol within the last 24 hours.

Y N Have you ever taken Fen-Phen or Redux?

Y N Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, ect.) for Osteoporosis or any other condition?

Y N I usually take antibiotic prior to dental treatment

Y N I have had major surgery Year _____ Type of operation _____

Year _____ Type of operation _____

Y N Do you have any other medical problems or medical history NOT listed on this form? _____

_____

_____

Y N Have you had any other serious illness, hospitalizations or accidents?

If yes, please explain? _____

Are you allergic to any of the following? (Please Circle Y for yes or N for no)

Y N Aspirin

Y N Ibuprofen

Y N Sulfa Drugs/Sulfites/Sulfides

Y N Penicillin

Y N Codeine

Y N Latex, Metals, Plastics

Y N Local Anesthetics (i.e., Novocain, Lidocaine)

Y N Any Other Medication Allergies? _____

Please list all medication you are currently taking:

Medicine: _____ Condition: _____

Medicine: _____ Condition: _____

Medicine: _____ Condition: _____

Medicine: _____ Condition: _____

Medicine: _____ Condition: _____

Medicine: _____ Condition: _____

Prescribing Physician's Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

In the event of an emergency please Contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____