

Date: _____

Patient Name: _____ Birth Date: _____
First Last MI

HEALTH INFORMATION

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

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? Yes! No If yes please, tell us why: _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(please circle each)

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 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 had 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.)

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

PATIENTS MEDICAL HISTORY

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

1. Y N Heart Disease

25. Y N Liver Disease

2. Y N Heart Murmur/Mitral Valve Prolapse

26. Y N Jaundice

3. Y N Stroke

27. Y N Hepatitis Type _____

4. Y N Congenital Heart Lesions

28. Y N Diabetes

5. Y N Rheumatic Fever

29. Y N Excessive Urination and/or Thirst

6. Y N Pacemaker

30. Y N Infectious Mononucleosis ("Mono")

7. Y N Stent.

31. Y N Herpes

8. Y N Abnormal Blood Pressure

32. Y N Arthritis

9. Y N Anemia

33. Y N Sexually Transmitted/Venereal Diseases

10. Y N Prolonged Bleeding Disorder

34. Y N Kidney Disease

11. Y N Tuberculosis or Lung Disease

35. Y N Tumor or Malignancy

12. Y N Asthma

36. Y N Cancer/Chemotherapy

13. Y N Hay Fever

37. Y N Radiation/Therapy

14. Y N Sinus Trouble

38. Y N History of Drug Addiction

15. Y N Epilepsy/Seizures

16. Y N Ulcers

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

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

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

20. Y N I usually take an antibiotic prior to dental treatment.

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

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

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

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

Doctor Notes Only:

- 39. Y N HIV
- 40. Y N AIDS
- 41. Y N Immune Suppressed Disorder
- 42. Y N Hearing Loss
- 43. Y N Fainting Spells
- 44. Y N Glaucoma
- 45. Y N History of Emotional or Nervous Disorders
- WOMEN:**
- 46. Y N Are you taking birth control medication?
- 47. Y N Are you or could you be pregnant or nursing?

Are you allergic to any of the following?

Please circle Y for yes or N for no

48. Y N Aspirin

49. Y N Ibuprofen

50. Y N Sulfite Drugs/Sulfites/Sulfides

51. Y N Penicillin

52. Y N Codeine

53. Y N Latex, Metals, Plastics

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

55. Y N Other Medications Which ones? _____

Please list all medications you are currently taking:

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Physician's Name _____ Phone _____

Address _____ Fax _____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____
Doctor's Signature Date

X _____
Patient's Signature Date

Periodic medical/dental health reviewed by:

X _____
Doctor's Signature Date

X _____
Patient's Signature Date

X _____
Doctor's Signature Date

X _____
Patient's Signature Date