Patient's Name _____ **Birth Date** _____

PATIENTS DENTAL HISTORY

Why have you come in 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? _____ What type of toothbrush do you use(electric or manual)? _____

Do you floss? ❑ Yes ❑ No How often? _____ Have you had a deep cleaning before? ❑ Yes ❑ No If Yes, what date: _____

(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 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 straight.

What are your dental priorities? _____
(e.g.: whitening, prevention, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be *(please check one)* ❑ Excellent ❑ Good ❑ Fair ❑ Poor

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

1 Y N Heart Disease
2 Y N Heart Murmur/Mitral 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 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 Fosamax or a similar bone density drug?
20. Y N I have had major surgery: Year _____ Type of operation: _____ Year _____ Type of operation: _____

22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis (Mono)
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Disease
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation Treatment
35. Y N History of Drug Addiction

Doctor Notes Only:

36. Y N AIDS/HIV
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

WOMEN

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

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

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

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

Please list all medications you are currently taking:

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____

Physician's Name Phone

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name Relationship Phone