

DENTAL & MEDICAL HISTORY

Patient Name: _____ Date: _____

DENTAL HISTORY

Have you experienced any of the following (please check all that apply):		
<input type="checkbox"/> chronic bad breath	<input type="checkbox"/> grinding or clenching of teeth	<input type="checkbox"/> sensitivity to hot
<input type="checkbox"/> bleeding gums	<input type="checkbox"/> loose teeth	<input type="checkbox"/> sensitivity to sweets
<input type="checkbox"/> jaw clicking or popping	<input type="checkbox"/> periodontal treatment	<input type="checkbox"/> sensitivity when biting
<input type="checkbox"/> food collection between teeth	<input type="checkbox"/> sores or growths in mouth	<input type="checkbox"/> sensitivity to cold
<input type="checkbox"/> locking jaw	<input type="checkbox"/> broken fillings	
Other: _____		

Rate your smile from 1 – 10: _____ What would you change: _____

Does dental treatment make you nervous? Yes No Are you happy with past treatment? Yes No

Have you ever had a negative experience in a dental office? Yes No

Please explain: _____

Do you usually have anesthesia with your dental treatment? _____

Have you had orthodontic work in the past? _____ Dates: _____

Have you had periodontal surgery? _____ Dates: _____

How long since you've seen a dentist? _____ Were X-Rays taken? Yes No

What was done at your last dental visit? _____

Have you lost any teeth? Yes No If so, why? _____ Were they replaced? Yes No

How often do you brush? _____ Floss? _____ What type of toothbrush do you use? Soft Medium Hard

MEDICAL HISTORY

Do you have or have you had any of the following conditions (please check all that apply):			
<input type="checkbox"/> Anemia/Blood Disorder	<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Inflammatory Disease	<input type="checkbox"/> Abnormal Bleeding
<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Respiratory/Lung Illness
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fainting/Dizzy Spells	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Abnormal Heart
<input type="checkbox"/> Bacterial Endocarditis	<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Heart Transplant	<input type="checkbox"/> Congenital Heart Disease
<input type="checkbox"/> Heart Disease/Attack/Surgery	<input type="checkbox"/> Heart Stent	<input type="checkbox"/> Hepatitis, any form	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Kidney Disease	When placed _____	<input type="checkbox"/> Liver Disease/Jaundice	When placed _____
<input type="checkbox"/> Sore/Enlarged Lymph Nodes	<input type="checkbox"/> Psychosis	<input type="checkbox"/> Previous biopsies	<input type="checkbox"/> Radiation/Chemo
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Slow Healing Mouth Sores	<input type="checkbox"/> Unintentional Weight Gain or Loss	
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other Conditions: _____	
Recurrent Illnesses: _____			

MEDICATION INFORMATION

Are you taking any of these medications (please check all that apply):	
<input type="checkbox"/> Pre-medications for dental treatment	<input type="checkbox"/> Tagament (cimetidine) or Prilosec (omeprazole)
<input type="checkbox"/> Antacids	<input type="checkbox"/> Cardizem (diltiazem) or Calan, Isoptin (verapamil)
<input type="checkbox"/> Dilatin or Tegretol	<input type="checkbox"/> Serzone (nefazodone)
<input type="checkbox"/> Barbiturates (any)	<input type="checkbox"/> Diflucan (fluconazole) or Sporonox (itraconazole)
<input type="checkbox"/> St. John's Wort or Kava-Kava	<input type="checkbox"/> Biaxin (clarithromycin)
Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, when did treatment begin: _____ End: _____	
Have you ever taken any prescription drugs such as fen-phen for weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you consume grapefruit juice, grapefruits or grapefruit extract? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Patient Name: _____ Date: _____

MEDICAL HISTORY CONTINUED

Physician Name: _____ Phone #: _____

Date of last health care exam: _____ Do you have any drug allergies? _____

Have you been hospitalized in the last 5 years? Yes No If yes, reason: _____

Are you currently receiving care? Yes No If yes, nature of care: _____

Please list the names and phone numbers of the physicians what are currently providing you care:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Please list all medications (prescription or non-prescription) that you are currently taking and reason for medication:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Do you have any known allergies (latex, etc.)? _____

Other known allergies? (i.e. pollen, etc.) _____

Do you drink: public water well water bottled water

Women:

Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Patient or Legal Guardian Signature: _____

Date: _____