

**Patients Dental Health**

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

Previous Dentist: ..... Last Visit : .....

Date of 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, tell us why: .....

How often do you brush your teeth? ..... Do you floss ? yes no How often ? .....

(please circle each)

- |     |  |     |                                    |
|-----|--|-----|------------------------------------|
| Y N | I clench or grind my teeth.                    | Y N | My gums feel tender or swollen.    |
| Y N | My gums bleed while brushing or flossing       | Y N | I have problems eating.            |
| Y N | I like my smile.                               | Y N | I have had orthodontics.           |
| Y N | I prefer tooth-colored fillings.               | Y N | I have had a facial or jaw injury. |
| Y N | I avoid brushing part of my mouth due to pain. | 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)

**Summary:**

**Patients 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 )

- |          |  |          |   |
|----------|--|----------|---|
| 1.- Y N  | Heart Disease  | 24.- Y N | Liver Disease                             |
| 2.- Y N  | Heart Murmur/Mitral Valve Prolapse   | 25.- Y N | Jaundice                                  |
| 3.- Y N  | Stroke   | 26.- Y N | Hepatitis Type .....                      |
| 4.- Y N  | Congenital Heart Lesions   | 27.- Y N | Diabetes Type .....                       |
| 5.- Y N  | Rheumatic Fever  | 28.- Y N | Excessive Urination and/or Thirst         |
| 6.- Y N  | Pacemaker  | 29.- Y N | Infectious Mononucleosis ("Mono")         |
| 7.- Y N  | Stent  | 30.- Y N | Herpes                                    |
| 8.- Y N  | Abnormal Blood Pressure (.....)  | 31.- Y N | Arthritis                                 |
| 9.- Y N  | Anemia   | 32.- Y N | Sexually Transmitted/Venereal Diseases.   |
| 10.- Y N | Prolonged bleeding disorder.   | 33.- Y N | Kidney Disease.                           |
| 11.- Y N | Tuberculosis or Lung Disease   | 34.- Y N | Tumor or Malignancy.                      |
| 12.- Y N | Asthma   | 35.- Y N | Cancer / Chemotherapy.                    |
| 13.- Y N | Hay Fever.   | 36.- Y N | Radiation / Therapy.                      |
| 14.- Y N | Sinus Trouble.   | 37.- Y N | History of Drug Addiction.                |
| 15.- Y N | Epilepsy / Seizures.   | 38.- Y N | HIV                                       |
| 16.- Y N | Ulcers.  | 39.- Y N | AIDS.                                     |
| 17.- Y N | Implant/Artificial Joint.  | 40.- Y N | Immune Suppressed Disorder.               |
| 18.- Y N | Smoke or chew tobacco.   | 41.- Y N | Hearing Loss.                             |
| 19.- Y N | I have consumed alcohol in the last 24h.   | 42.- Y N | Fainting Spells.                          |
| 20.- Y N | I usually take an antibiotic prior to dental treatment.                                | 43.- Y N | Glaucoma.                                 |
| 21.- Y N | Have you ever Fen-Phen or Redux?   | 45.- Y N | Are you taking birth control medication?  |
| 22.- Y N | I have had major surgery.  | 46.- Y N | Are you or could you pregnant or nursing? |
|          | Year..... Type of Operation.....   |          |   |
|          | Year..... Type of Operation.....   |          |   |
| 23.- Y N | Do you have any other medical problem or medical history NOT listed on this form?..... |          |   |

Are you allergic to any of the following::

- |         |                                     |
|---------|-------------------------------------|
| 47.-Y N | Aspirin.                            |
| 48.-Y N | Ibuprofen.                          |
| 49.-Y N | Sulfa Drugs/Sulfites?Sulfides       |
| 50.-Y N | Penicillin.                         |
| 51.-Y N | Codeine.                            |
| 52.-Y N | Latex, Metal, Plastics.             |
| 53.-Y N | Local Anesthetics (lidocaine)       |
| 54.-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: (.....) |
| Address:.....         |                |
| Fax:.....             |                |

In the event of an emergency please contact:

Name:..... Relationship:..... Phone: (.....)  
 Name:..... Relationship:..... Phone: (.....)

**Initial Medical/Dental Health filled out by:**

X..... /...../.....  
 Patient/Guardian's Signature Date

**Periodic Medical/Dental Health filled out by:**

Has there been any change in your health since your last exam?.....

What condition.....:..... New Medication:.....

..... /...../.....  
 Patient/Guardian's Signature Date

What condition.....:..... New Medication:.....

X..... /...../.....  
 Patient/Guardian's Signature Date

**Initial Medical/Dental Health reviewed by:**

X..... /...../.....  
 Dentist's Signature Date

**Periodic Medical/Dental Health filled out by:**

Comments:.....

..... /...../.....

Dentist's Signature Date

Comments:.....

X..... /...../.....  
 Dentist's Signature Date