

PATIENTS DENTAL HEALTH

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? _____ 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 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 straight.
	Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: apprentice, dental health, 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: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> 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 Fen-Phen or Redux? 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
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Doctor Notes Only:

36. Y N AIDS 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	<p>WOMEN</p> 42. Y N Are you taking birth control medication? 43. Y N Are you or could you be pregnant or nursing?
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21. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

<p>Are you allergic to any of the following? Please circle Y for yes or N for no</p> 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? _____	<p>Please list all medications you are currently taking:</p> Medicine _____ Condition _____ Medicine _____ Condition _____ Medicine _____ Condition _____ Medicine _____ Condition _____ Physician's Name _____ Phone _____ Address _____ Fax _____
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In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT