PATIENTS DENTAL HEALTH

NAME : _____ **DATE OF BIRTH :** _____

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 whiter
Y N I want my teeth straight(er)

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?

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 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
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

Doctor Notes Only :

WOMEN

42. **Y N** Are you taking birth Control Med?
43. **Y N** Are you or could you be pregnant or nursing?

21. **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?

44. **Y N** Aspirin
45. **Y N** Ibuprofen
46. **Y N** Sulfa Drugs/Sulfites
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_____
Medicine _____ Condition_____
Medicine _____ Condition_____
Medicine _____ Condition_____
Physician's Name _____ 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 Patient's Signature Date