

Patient Name: \_\_\_\_\_

Patient's D.O.B: \_\_\_\_\_

Date: \_\_\_\_\_

### 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	22. Y N Liver Disease	<b>Doctor Notes Only:</b>
2. Y N Heart Murmur/Mitral Valve Prolapse	23. Y N Jaundice	
3. Y N Stroke	24. Y N Hepatitis Type_____	
4. Y N Congenital Heart Lesions	25. Y N Diabetes	
5. Y N Rheumatic Fever	26. Y N Excessive Urination and/or Thirst	
6. Y N Abnormal Blood Pressure	27. Y N Infectious Mononucleosis (Mono)	
7. Y N Anemia	28. Y N Herpes	
8. Y N Prolonged Bleeding Disorder	29. Y N Arthritis	
9. Y N Tuberculosis or Lung Disease	30. Y N Sexually Transmitted/Venereal Disease	
10. Y N Asthma	31. Y N Kidney Disease	
11. Y N Hay Fever	32. Y N Tumor or Malignancy	
12. Y N Sinus Trouble	33. Y N Cancer/Chemotherapy	
13. Y N Epilepsy/Seizures	34. Y N Radiation Treatment	
14. Y N Ulcers	35. Y N History of Drug Addiction	
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: _____		

21. Y N Do you have any other medical problem or medical history NOT listed on this form? \_\_\_\_\_

<p><b>Are you allergic to any of the following?</b> Please circle Y for yes or N for no</p> <p>44. Y N Aspirin</p> <p>45. Y N Ibuprofen</p> <p>46. Y N Sulfa Drugs/Sulfites/Sulfides</p> <p>47. Y N Penicillin</p> <p>48. Y N Codeine</p> <p>49. Y N Latex, Metals, Plastics</p> <p>50. Y N Local Anesthetics (Novocaine)</p> <p>51. Y N Other Medications - Which ones? _____</p>	<p><b>Please list all medications you are currently taking:</b></p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Physician's Name _____ Phone _____</p> <p>Address _____ Fax _____</p>
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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