

DENTAL HISTORY:

REASON FOR VISIT: _____ LAST DENTAL VISIT: _____ LAST X-RAYS: _____

FORMER DENTIST: _____ PHONE: _____

- | | | | |
|---|----------|--------------------------------|----------|
| 1. Are you currently in pain? | Yes / No | DO YOU FLOSS? | YES / NO |
| 2. Do you require antibiotics for dental treatment? | Yes / No | DO YOU BRUSH | YES / NO |
| 3. Have you ever had periodontal disease? | Yes / No | ARE YOU HAPPY WITH YOUR SMILE? | YES / NO |
| 4. Do you have loose teeth or broken fillings? | Yes / No | DO YOU WANT WHITER TEETH? | YES / NO |
| 5. Would you like fresher breath? | Yes / No | ARE YOUR TEETH SENSITIVE? | YES / NO |
| 6. Do your gums ever bleed? | Yes / No | TO: HOT / COLD / SWEETS | |

MEDICAL HISTORY:

PHYSICIAN'S NAME: _____ PHONE: _____

CURRENT PHYSICAL HEALTH IS: GOOD FAIR POOR ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES / NO

REASON: _____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? YES / NO DATES: _____

WOMEN: ARE YOU PREGNANT? YES / NO # OF WEEKS: _____ ARE YOU NURSING? YES / NO

ARE YOU TAKING BIRTH CONTROL PILLS? YES / NO

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- | | | |
|---|--|---|
| <input type="checkbox"/> ABNORMAL BLEEDING | <input type="checkbox"/> DIABETES | <input type="checkbox"/> MIGRAINES |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> ALCOHOL / DRUG ABUSE | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> NERVOUS PROBLEMS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ARTHRITIS, RHEUMATISM | <input type="checkbox"/> FAINTING | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> RADIATION TREATMENT |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> RHEUMATIC/SCARLET FEVER |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> BLOOD TRANSFUSIONS | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> SKIN RASH |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEPATITIS – TYPE _____ | <input type="checkbox"/> SICKLE CELL ANEMIA |
| <input type="checkbox"/> CHF | <input type="checkbox"/> HERPES/FEVER BLISTERS | <input type="checkbox"/> SWELLING OF FEET OR ANKLES |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SHINGLES |
| <input type="checkbox"/> COLITIS | <input type="checkbox"/> HIV POSITIVE | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> COPD | <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> CORTISONE TREATMENT | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CONGENITAL HEART DEFECTS | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TUMORS/GROWTHS ON HEAD OR NECK |
| <input type="checkbox"/> COUGH, PERSISTANT | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> COUGH UP BLOOD | <input type="checkbox"/> LATEX SENSITIVITY/ALLERGY | <input type="checkbox"/> VENEREAL DISEASE |

MEDICATIONS: _____

ALLERGIES: _____

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT, WITH MY INFORMED CONSENT.

SIGNATURE: _____ DATE: _____