Patient Name _____

PATIENT'S DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____

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 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 straight.
Y N I want my teeth whiter.

What are your dental priorities? _____

PATIENT'S 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: ☐ 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-Pen 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

Please update phone #

_____

WOMEN

42. Y N Are you taking birth control medication?
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?
Please check Y for yes or N for no

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? _____

Please list all medications you are currently taking:

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 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