

DENTAL HISTORY

Reason for today's visit _____

Date of last dental care _____ Date of last dental x-rays _____

Check if you have had problems with any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot/cold |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth/broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food caught between teeth | <input type="checkbox"/> Sores/growths in mouth | <input type="checkbox"/> Fear of dental treatment |
| <input type="checkbox"/> Unsatisfactory appearance of your teeth | | |

How often do you floss? _____ Brush? _____ Is there fluoride in your drinking water? _____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Date of last visit _____

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Has there been any problem with your general health in the last year? (illnesses, operations)
If yes, describe _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you now under the care of a physician? If yes, what is the condition being treated?
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking or have you taken any medicines, including nonprescription medicine?
Prescribed _____
Over the counter or herbal preparations _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you taken any diet drugs, such as Pondimin, Redux, or Phen-fen? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you alcohol and/or drug dependent? If so, have you received treatment? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco (smoking, snuff, chew)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Women, are you pregnant? _____ Nursing? _____ Taking birth control pills? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an orthopedic joint replacement? If so, when was this done? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has a physician or previous dentist recommended that you take antibiotics before your dental treatment? If so, what antibiotic and dose?
_____ |

Check if you have had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory problems
____ Emphysema
____ Bronchitis |
| <input type="checkbox"/> AIDS or HIV positive | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating disorder _____ | <input type="checkbox"/> Severe headaches, migraines |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Severe or rapid weight loss |
| <input type="checkbox"/> Asthma, hay fever | <input type="checkbox"/> Fainting spells or seizures | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Blood transfusion, date | <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Cancer/chemotherapy/radiation | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Herpes lesions | <input type="checkbox"/> Stroke |
| If yes, specify: | <input type="checkbox"/> Hepatitis, liver disease | <input type="checkbox"/> Thyroid problems |
| ____ Angina | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| ____ Artificial heart valves | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Ulcers |
| ____ Heart attack | <input type="checkbox"/> Mental health disorder
If yes, _____ | |
| ____ Heart murmur | <input type="checkbox"/> Malnutrition | |
| ____ High blood pressure | <input type="checkbox"/> Osteoporosis | |
| ____ Mitral valve prolapse | <input type="checkbox"/> Persistent cough, cough up blood | |
| ____ Other _____ | | |

Do you have any disease, condition or problem not listed that we should know about? Please explain: _____

Allergies: Are you allergic to or have you had a reaction to:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills | <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> Other _____ |

To yes responses, specify type of reaction _____

DDS use: Significant findings: _____

Signature of Patient/Legal Guardian _____ Date _____