

PATIENT DENTAL HISTORY

PATIENT NAME _____

YES NO

YES NO

- | | | | | | |
|---|-----------------------|-----------------------|---|-----------------------|-----------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="radio"/> | <input type="radio"/> | 8. Do you have frequent headaches? | <input type="radio"/> | <input type="radio"/> |
| 2. Are your teeth sensitive to hot or cold? | <input type="radio"/> | <input type="radio"/> | 9. Do you clench or grind your teeth? | <input type="radio"/> | <input type="radio"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="radio"/> | <input type="radio"/> | 10. Do you bite your lips or cheeks frequently? | <input type="radio"/> | <input type="radio"/> |
| 4. Do you feel pain in any of your teeth? | <input type="radio"/> | <input type="radio"/> | 11. Have you ever had any difficult extractions in the past? | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="radio"/> | <input type="radio"/> | 13. Have you ever had prolonged bleeding following extractions? | <input type="radio"/> | <input type="radio"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="radio"/> | <input type="radio"/> | 12. Have you had any orthodontic work? | <input type="radio"/> | <input type="radio"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Have you ever had instruction on the correct method of brushing your teeth? | <input type="radio"/> | <input type="radio"/> |
| a) Clicking? | <input type="radio"/> | <input type="radio"/> | 15. Have you ever had instructions on the care of your gums? | <input type="radio"/> | <input type="radio"/> |
| b) Pain (joint, ear, side of face)? | <input type="radio"/> | <input type="radio"/> | | | |
| c) Difficulty in opening or closing? | <input type="radio"/> | <input type="radio"/> | | | |
| d) Difficulty in chewing? | <input type="radio"/> | <input type="radio"/> | | | |

What is the reason for your visit today? _____

Date of last dental visit _____ Previous Dentist _____

What was done at your last dental visit? _____

Are you satisfied with your teeth's appearance? Yes No

What would you change about your smile? _____

Do you brush, floss or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____

PATIENT, PARENT OR GUARDIAN

DATE

MEDICAL HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST PHYSICAL _____

HEIGHT _____ WEIGHT _____ INDICATE ANY PREMEDICATIONS _____

- | | | | | | |
|--|-----------------------|-----------------------|---|--|---|
| | YES | NO | | | |
| 1. Are you under medical treatment now?
If yes, for what? _____
_____ | <input type="radio"/> | <input type="radio"/> | 7. Are you allergic to or have you had any reactions to the following? | | |
| | | | YES NO | YES NO | YES NO |
| 2. Have you ever been hospitalized for any surgical operation or serious illness? If yes, for what? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> <input type="radio"/> Local anesthetics | <input type="radio"/> <input type="radio"/> Sedatives | <input type="radio"/> <input type="radio"/> Iodine |
| | | | <input type="radio"/> <input type="radio"/> Penicillin or other antibiotics | <input type="radio"/> <input type="radio"/> Food Allergies | <input type="radio"/> <input type="radio"/> Metal |
| 3. Are you taking any medication(s) including non-prescription medicine?
If yes, what medication(s)/vitamins are you taking? _____
_____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> <input type="radio"/> Sulfa drugs | <input type="radio"/> <input type="radio"/> Codeine | <input type="radio"/> <input type="radio"/> Other _____ |
| | | | <input type="radio"/> <input type="radio"/> Latex | <input type="radio"/> <input type="radio"/> Erythromycin | <input type="radio"/> <input type="radio"/> Aspirin _____ |
| 4. Do you use tobacco? | <input type="radio"/> | <input type="radio"/> | 8. WOMEN ONLY: | | YES NO |
| 5. Do you use alcohol? | <input type="radio"/> | <input type="radio"/> | Are you pregnant or think you may be pregnant? | <input type="radio"/> | <input type="radio"/> |
| 6. Do you use recreational drugs? | <input type="radio"/> | <input type="radio"/> | Are you nursing? | <input type="radio"/> | <input type="radio"/> |
| | | | Are you taking birth control pills? | <input type="radio"/> | <input type="radio"/> |

9. Do you have or have you had any of the following?

- | | | |
|---|--|--|
| YES NO | YES NO | YES NO |
| <input type="radio"/> <input type="radio"/> Aids or HIV Infection | <input type="radio"/> <input type="radio"/> Frequently Tired | <input type="radio"/> <input type="radio"/> Liver Disease |
| <input type="radio"/> <input type="radio"/> Anemia | <input type="radio"/> <input type="radio"/> Glaucoma | <input type="radio"/> <input type="radio"/> Low Blood Pressure |
| <input type="radio"/> <input type="radio"/> Angina | <input type="radio"/> <input type="radio"/> Hay Fever/Allergies | <input type="radio"/> <input type="radio"/> Osteoporosis |
| <input type="radio"/> <input type="radio"/> Arthritis | <input type="radio"/> <input type="radio"/> Heart Attack | <input type="radio"/> <input type="radio"/> Radiation Therapy |
| <input type="radio"/> <input type="radio"/> Asthma | <input type="radio"/> <input type="radio"/> Heart Disease | <input type="radio"/> <input type="radio"/> Recent Weight Loss |
| <input type="radio"/> <input type="radio"/> Blood Transfusion | <input type="radio"/> <input type="radio"/> Heart Murmur | <input type="radio"/> <input type="radio"/> Respiratory Problems |
| <input type="radio"/> <input type="radio"/> Cancer | <input type="radio"/> <input type="radio"/> Heart Trouble | <input type="radio"/> <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> <input type="radio"/> Cardiac Pacemaker | <input type="radio"/> <input type="radio"/> Hemophilia | <input type="radio"/> <input type="radio"/> Sexually Transmitted Disease |
| <input type="radio"/> <input type="radio"/> Chest Pains | <input type="radio"/> <input type="radio"/> Hepatitis/Jaundice | <input type="radio"/> <input type="radio"/> Shingles |
| <input type="radio"/> <input type="radio"/> Colitis | <input type="radio"/> <input type="radio"/> High Blood Pressure | <input type="radio"/> <input type="radio"/> Sleep Apnea |
| <input type="radio"/> <input type="radio"/> Diabetes Type I or II | <input type="radio"/> <input type="radio"/> High Cholesterol | <input type="radio"/> <input type="radio"/> Stomach Troubles/Ulcers |
| <input type="radio"/> <input type="radio"/> Easily Winded | <input type="radio"/> <input type="radio"/> Hyper/Hypo Thyroid | <input type="radio"/> <input type="radio"/> Stroke |
| <input type="radio"/> <input type="radio"/> Emphysema | <input type="radio"/> <input type="radio"/> Joint Replacement or Implant | <input type="radio"/> <input type="radio"/> Swollen Ankles |
| <input type="radio"/> <input type="radio"/> Epilepsy/Convulsions | <input type="radio"/> <input type="radio"/> Kidney Diseases | <input type="radio"/> <input type="radio"/> Tuberculosis |
| <input type="radio"/> <input type="radio"/> Fainting /Seizures | <input type="radio"/> <input type="radio"/> Leukemia | <input type="radio"/> <input type="radio"/> Other _____ |

COMMENTS _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____ DATE _____
PATIENT, PARENT OR GUARDIAN

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