PATIENT INFORMATION

Name: _____ Date of Birth: _____

Residential Address_____City_____State_____Zip_____

Phone_____ Referred by: _____

Your Dentist: _____City_____How long? _____

Your Physician: _____City_____Phone: _____

Date of Last Physical Examination: _____Purpose of examination: _____

MEDICAL HEALTH HISTORY

History of smoking? Yes No If **YES**, how many per day: _____ How long? _____ Quit date: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

HEART PROBLEMS

Chest Pain..... ❒
High Blood Pressure..... ❒
Heart Murmur..... ❒
Angina Pectoris..... ❒
Taking Heart Medication..... ❒
Rheumatic Fever..... ❒
Pacemaker..... ❒
Artificial Heart Valve..... ❒
Mitral Valve Prolapse..... ❒
Congenital Heart Lesions..... ❒
Heart Attack..... ❒
Bypass..... ❒

Stroke..... ❒
Diabetes..... ❒
Stomach Ulcers..... ❒
Kidney Trouble..... ❒
Fainting Spells or Epilepsy..... ❒
Glaucoma..... ❒

Infectious Diseases..... ❒
HIV Positive..... ❒
AIDS..... ❒
Hepatitis (A) (B) (C)..... ❒
Liver Disease..... ❒
Yellow Jaundice..... ❒
Cold Sores..... ❒

BONE OR JOINT PROBLEMS

Joint Replacement..... ❒
Implants..... ❒
Arthritis..... ❒
Cortisone Medicine..... ❒
Pain in Joints..... ❒
Osteoporosis..... ❒

RESPIRATORY DISEASE

Tuberculosis..... ❒
Emphysema..... ❒
Asthma..... ❒
Sinus Problems..... ❒
Hay Fever..... ❒

BLOOD PROBLEMS

Easy Bruising ..... ❒
Blood Transfusion ..... ❒
Abnormal Bleeding..... ❒
Hemophilia..... ❒
Anemia..... ❒

Cancer/Tumor..... ❒
Chemotherapy..... ❒
Radiation Treatment..... ❒

Physical Limitation ..... ❒
Hearing Impairment ..... ❒
Psychiatric Treatment ..... ❒
Depression..... ❒

Drug Addiction ..... ❒
Alcoholism ..... ❒
Chewing Tobacco ..... ❒

AN ALLERGIC REACTION TO:

Aspirin..... ❒
Codeine..... ❒
Dental Anesthetic ..... ❒
Erythromycin ..... ❒
Penicillin ..... ❒
Sedatives or Sleeping Pills..... ❒
Sulfa ..... ❒
Tetracycline ..... ❒
Other..... ❒
List_____

IF FEMALE, ARE YOU:

Taking birth control pills ..... ❒
Pregnant ..... ❒
Trying to conceive ..... ❒
Presently in menopause ..... ❒
Past menopause ..... ❒

Is there anything else we should know about your medical history? _____
_____
_____

WHAT MEDICATIONS ARE YOU TAKING NOW?

Medication: _____Condition:_____How Long? _____
Medication: _____Condition:_____How Long? _____
Medication: _____Condition:_____How Long? _____
Medication: _____Condition:_____How Long? _____
Medication: _____Condition:_____How Long? _____

What is your estimate of your dental health? ❒ Good ❒ Fair ❒ Poor

What specific dental concerns do you have now? _____

_____

_____

Please describe your long-term goals for your mouth and teeth: _____

_____

_____

How long since your last dental visit? _____

What was done? _____

When was your last cleaning? _____

How frequently do you have your teeth professionally cleaned? _____

How often do you brush? _____ Floss? _____

Do you grind or clench your teeth? ❒ Yes ❒ No

If so, do you ❒ ***currently*** or have you ❒ ***previously*** worn a night guard?

Have you ever been treated for Gum Disease? ❒ Yes ❒ No

If so, when? _____

What was done? ❒ Deep cleaning ❒ Gum surgery ❒ Gum grafts

Which of the following dental services have you received?

❒ Extractions Reason: ❒ Decay/Broken Down ❒ Loose/Bone Loss
❒ Wisdom teeth ❒ Other: _____

❒ Root Canals _____

❒ Crowns or Caps _____

❒ Braces Start year: _____ Completion year: _____

❒ Implants _____

❒ Other: _____

Have you had problems or undesirable experiences with previous dental treatment? ❒ Yes ❒ No

What can we do to make you most comfortable? _____

Is there anything else you would like us to be aware of? _____

_____

Notations (for office use):

_____

Date Signature of Patient, Parent, or Guardian Reviewed By

_____

Health History Updated Signature of Patient, Parent, or Guardian Reviewed By

_____

Health History Updated Signature of Patient, Parent, or Guardian Reviewed By

HEIGHT _____

WEIGHT _____