Patients Dental Health

Why have you come to see us? (e.g.: tooth ache, checkup, etc)……
Previous Dentist: .....Last Visit :.....
Date of last cleaning:..... Reason for changing dentist.....
What problems have you had with past dental treatment?
.....
Are you nervous about seeing a dentist? Yes No If yes please, tell us why: .....

How often do you brush your teeth? ..... Do you floss ? yes no How often ? .....
(please circle each)

Y N	I clench or grind my teeth.	Y N	My gums feel tender or swollen.
Y N	My gums bleed while brushing or flossing	Y N	I have problems eating.
Y N	I like my smile.	Y N	I have had orthodontics.
Y N	I prefer tooth-colored fillings.	Y N	I have had a facial or jaw injury.
Y N	I avoid brushing part of my mouth due to pain.	Y N	I want my teeth straighter
Y N	I want my teeth whiter.		

What are your dental priorities? ……
(e.g.: appearance, dental health, financial considerations, etc)

Patients Medical History

I consider my health to be: (check one) : Excellent Good Fair Poor
Do you have or have you had any of the following? (Please circle Y for yes or N for no)

1.- Y N	Heart Disease	24.- Y N	Liver Disease
2.- Y N	Heart Murmur/Mitral Valve Prolapse	25.- Y N	Jaundice
3.- Y N	Stroke	26.- Y N	Hepatitis Type .....
4.- Y N	Congenital Heart Lesions	27.- Y N	Diabetes Type .....
5.- Y N	Rheumatic Fever	28.- Y N	Excessive Urination and/or Thirst
6.- Y N	Pacemaker	29.- Y N	Infectious Mononucleosis ("Mono")
7.- Y N	Stent	30.- Y N	Herpes
8.- Y N	High Blood Press	31.- Y N	Arthritis
9.- Y N	Anemia	32.- Y N	Sexually Transmitted/Venereal Diseases.
10.- Y N	Prolonged bleeding disorder.	33.- Y N	Kidney Disease.
11.- Y N	Tuberculosis or Lung Disease	34.- Y N	Tumor or Malignancy.
12.- Y N	Asthma	35.- Y N	Cancer / Chemotherapy.
13.- Y N	Hay Fever.	36.- Y N	Radiation / Therapy.
14.- Y N	Sinus Trouble.	37.- Y N	History of Drug Addiction.
15.- Y N	Epilepsy / Seizures.	38.- Y N	HIV
16.- Y N	Ulcers.	39.- Y N	AIDS.
17.- Y N	Implant/Artificial Joint.	40.- Y N	Immune Suppressed Disorder.
18.- Y N	Smoke or chew tobacco.	41.- Y N	Hearing Loss.
19.- Y N	I have consumed alcohol in the last 24h.	42.- Y N	Fainting Spells.
20.- Y N	I usually take an antibiotic prior to dental treatment.	43.- Y N	Glaucoma.
			WOMEN
21.- Y N	High Cholesterol	45.- Y N	Are you taking birth control medication?
22.- Y N	I have had major surgery.	46.- Y N	Are you or could you be pregnant or nursing?
	Year..... Type of Operation.....		
	Year..... Type of Operation.....		
23.-Y N	Do you have any other medical problem or medical history NOT listed on this form?.....		

Summary:

Are you allergic to any of the following::

47.-Y	N	Aspirin.
48.-Y	N	Ibuprofen.
49.-Y	N	Sulfa Drugs/Sulfites?Sulfides
50.-Y	N	Penicillin.
51.-Y	N	Codeine.
52.-Y	N	Latex, Metal, Plastics.
53.-Y	N	Local Anesthetics (lidocaine)
54.-Y	N	Other Medications; Which ones?.....

…….

Please list all medications you are currently taking:

Medicine.....Condition.....
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 filled out by:

X..... ……/……/.....
Patient/Guardian's Signature Date

Periodic Medical/Dental Health filled out by:

Has there been any change in your health since your last exam?.....

What condition……..:……New Medication:……..

…… ……/……/.....
Patient/Guardian's Signature Date

What condition……..:……New Medication:……

X..... ……/……/.....
Patient/Guardian's Signature Date

Initial Medical/Dental Health reviewed by:

X..... ……/……/.....
Dentist's Signature Date

Periodic Medical/Dental Health filled out by:

Comments:……

……

…… ……/……/.....
Dentist's Signature Date

Comments::……

X..... ……/……/.....
Dentist's Signature Date