

PATIENT HEALTH INFORMATION

Today's Date ____/____/____

Patient Name _____

Birthdate ____/____/____

It is important that we know about your medical and dental history. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone without your prior approval. Thank you for taking the time to completely fill out this form.

DENTAL HISTORY

Are you anxious about dental care? _____

How long since your last dental visit? _____

Last COMPLETE dental exam. Date _____

Are you having problems now? _____

What are they? _____

Circle Each YES Response

1. Do you have any of the following:

- Broken / rough fillings
- Decayed teeth
- Bleeding, irritated gums
- Missing teeth
- Loose teeth
- Jaw or joint pain
- Clicking / popping jaw joint
- Pain / ringing in the ears
- Food catches between teeth

2. Are your teeth sensitive to hot or cold?

3. Are your teeth sensitive to sweets, pressure?

4. Are you aware of grinding/clenching of your teeth?

5. Do you have headaches, earaches, or neck pains?

6. Have you worn braces on your teeth?

7. Are you unhappy with the appearance of your teeth?

8. Do you have discolored teeth that bother you?

9. Do you regularly use dental floss?

10. Would you like your smile to look better or different? How do you feel about your teeth?

Please RANK the following in the order in which they would keep you from having dental treatment? (Use 1 through 4) 1= Least likely to keep you from treatment; 4= Most likely.

FEAR of pain

COST of treatment

LACK of concern

MISSING work time

Name of Previous Dentist _____

City, State _____

Phone _____

MEDICAL HISTORY

Do you have any current health problems?

Are you under a physician's care now? _____

For what? _____

What medications are you currently taking?

Are you pregnant? _____

Do you smoke? _____

Circle any of the following which you have had or presently have:

- Heart Disease or Attack
- Angina Pectoris
- Tuberculosis TB
- High Blood Pressure
- Heart Murmur
- Rheumatic Fever
- Congenital Heart Lesions
- Mitral Valve Prolapse
- Artificial Heart Valve
- Sinus Trouble
- Heart Pacemaker
- Heart Surgery
- Nervousness
- Artificial Joints: Hip, Knee
- Stroke
- Cortisone Medication
- Pain in Jaw Joints
- Venereal Disease (Syphilis, Gonorrhea, Etc.)
- Cosmetic Surgery
- Hay Fever
- Allergies
- Arthritis
- Alcoholism
- AIDS / HIV positive
- Hepatitis A (Infectious)
- Hepatitis B (Serum)
- Emphysema
- Liver Disease
- Blood Transfusion
- Drug Addiction
- Hemophilia
- Fever Blisters
- Ulcers
- Epilepsy / Seizures
- Thyroid Disease
- Radiation Treatment
- Psychiatric Treatment
- Anemia
- Chemotherapy
- Kidney Trouble
- Bruise Easily
- Asthma
- Diabetes
- Glaucoma

Are you allergic to or have you REACTED ADVERSELY to any of the following medications?

- Local Anesthetic
- Nitrous Oxide
- Penicillin
- Erythromycin
- Aspirin
- Codeine

Are you allergic to any other medications or substances? _____

If yes, please list: _____

Family Physician _____

Telephone _____

To the best of my knowledge, the medical and dental history presented are true and correct. I will notify this office of any change in health or medication

Signature _____

Print your name _____

Today's date _____