

PATIENT NAME _____

DATE _____

Please Circle

DENTAL HISTORY

- Do you have a specific dental problem?..... Yes No
- Do you think you have active decay or gum disease?..... Yes No
- Do you brush and floss on a daily basis?..... Yes No
- Do your gums ever bleed?..... Yes No
- Does food catch between your teeth?..... Yes No
- Do you ever have clicking, popping or discomfort in the jaw joint?..... Yes No
- Do you brux or grind your teeth?..... Yes No
- Do you smoke or chew tobacco products?..... Yes No
- Do you like your smile?..... Yes No

If the answer to the above questions is No, what do you wish you could change about your smile?

On a scale of 0 to 5 how would you rate your anxiety level when coming to the dentist?					
0 (no anxiety)	1	2	3	4	5 (extremely anxious)

MEDICAL HISTORY

- Are you under a physician's care currently?..... Yes No
- What are you being treated for? _____
- Physician's name _____ Phone # _____
- Have you ever been hospitalized or had a major operation?..... Yes No
- Have you ever had a serious injury to your head or neck?..... Yes No
- Are you taking any medications, aspirin, vitamins, herbals, pills or drugs?..... Yes No
- Are you on a special diet? Describe: _____
- Are you allergic to any medications or substances? Please check below

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other _____

Women (please check) Pregnant/Trying to get pregnant Nursing Taking Oral Contraceptives

Do you now have or have you ever had any of the following? Please check each box. If yes to any of the conditions printed in pink call prior to your appointment...premedication or changes in medication may be required.

	Y	N		Y	N		Y	N		Y	N		Y	N
Heart Disease/Surgery			Excessive Bleeding			Kidney Problems			Night Sweats			Cold Sores		
Heart Murmur/Defect			Sickle Cell Disease			Thyroid Disease			Yellow Jaundice			Fever Blisters		
Irregular Heart Beat			Hemophilia			Parathyroid			Stroke			Herpes		
Angina/Chest Pain			Methemoglobinemia			Osteoporosis			Renal Dialysis			Convulsions		
Heart Attack/Failure			Leukemia			Bisphosphonates			Arthritis/Gout			Glaucoma		
Congenital Heart Disorder			Chemotherapy			Aredia I.V.			Rheumatism			Hives/Rash		
Mitral Valve Prolapse			Tumors or Growths			Reclast I.V.			Genital Herpes			Nervousness		
Scarlet Fever			Swelling of Limbs			Zometa I.V.			AIDS			Alzheimer's		
Rheumatic Fever			Lung Disease			Fosamax			HIV Positive				Y	N
Artificial Heart Valve			Breathing Problem			Actonel			Allergies to any Medicines?					
Heart Pace Maker			Shortness of Breath			Boniva			Allergies to Pollen/Dust?					
Pulmonary Shunt			Frequent Cough			Stomach Disease			Cochlear Implants?					
High Blood Pressure			Hay Fever			Intestinal Disease			Osteonecrosis of the Jaw					
Low Blood Pressure			Sinus Trouble			Ulcers			Pain in Jaw Joints					
Bacterial Endocarditis			Asthma			Diabetes			Epilepsy of Seizures					
Unexplained Fever			Bloody Sputum			Excessive Thirst			Fainting or Dizziness					
Bruise Easily			Emphysema			Liver Disease			Tattoos or Body Piercing					
Blood Disorder			Tuberculosis			Hepatitis A			Drug Addiction/Alcoholism					
Anemia			Cancer			Hepatitis B or C			Sexually Transmitted Disease					
Recent Blood Transfusion			Frequent Diarrhea			Protease Inhibitor			Psychiatric Care					
Coronary Stent			Recent Weight Loss			Cortisone Med.			Ever taken fen-phen ?					
Artificial Joint						Premedication ?			X-ray Treatment (Radiation)					

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at my next appointment.

X _____ Date _____