DENTAL HISTORY

Name of former dentist _____

Date of last dental examination _____

Why are you seeking dental care today? _____

How did you hear about us?

❍ Yellow Pages ❍ Internet ❍ Friend ❍ Family Member ❍ Other

❍ Referral, whom _____

	YES	NO
Do you have teeth sensitive to cold?	❍	❍
Do you have teeth sensitive to hot?	❍	❍
Do you have teeth sensitive to sweets?	❍	❍
Do you have teeth sensitive to pressure?	❍	❍
Do you catch food between any teeth?	❍	❍
Do your gums bleed when you brush?	❍	❍
Have you had periodontal treatment?	❍	❍
Do you have swelling or lumps in your mouth?	❍	❍
Have you had frequent blisters or sores on your lips or mouth?	❍	❍
Do you have pain or noise in your jaw joint?	❍	❍
Do you grind or clench your teeth?	❍	❍
Have you ever been treated for a TMJ disorder?	❍	❍
Have you had orthodontic treatment?	❍	❍
Have you had root canal treatment?	❍	❍
Have your wisdom teeth been removed?	❍	❍
Do you have any missing teeth?	❍	❍
If yes, are you interested in replacing them?	❍	❍
Would you like to keep your teeth to avoid dentures?	❍	❍
Are you satisfied with your smile and the appearance of your teeth?	❍	❍
Have you been satisfied with your previous dental care?	❍	❍

If not, please explain _____

How often do you brush your teeth? _____

What texture is your toothbrush? Soft ❍ Medium ❍ Hard ❍

How often do you floss your teeth? _____

Is there any information not listed above that you feel is important to your dental care? _____

Please explain _____

_____

_____

_____

MEDICAL HISTORY

Please check correct response and indicate any medications taken where appropriate.

Patient's Name _____

Name of Medical Doctor _____

Date of last physical examination _____

	Yes	No
Are you presently under the care of a physician? _____	❍	❍
If so, for what? _____		
Has there been any change in your health within the past year? _____	❍	❍
What medications are you taking? _____		
_____		
_____		
Allergy to penicillin, or other antibiotics _____	❍	❍
List any other allergies_____		
Allergy to latex _____	❍	❍
Rheumatic Fever _____	❍	❍
Heart Murmur _____	❍	❍
Mitral Valve Prolapse _____	❍	❍
Heart ailments, disease _____	❍	❍
Heart surgery _____	❍	❍
Pacemaker _____	❍	❍
Artificial (prosthetic) heart valve _____	❍	❍
Previous infective endocarditis _____	❍	❍
Damaged valves in transplanted heart_____	❍	❍
Congenital heart disease (CHD) _____	❍	❍
Unrepaired, cyanotic CHD _____	❍	❍
Repaired (completely) in last 6 months _____	❍	❍
Repaired CHD with residual defects _____	❍	❍
High blood pressure _____	❍	❍
Anticoagulant therapy _____	❍	❍
Excessive bleeding from a cut, surgery or extraction _____	❍	❍
Anemia, blood problems, leukemia _____	❍	❍
Have you ever required a blood transfusion? _____	❍	❍
Prosthetic joint surgery _____	❍	❍
Date:_____ If yes, have you had any complications?	❍	❍
Emphysema, asthma _____	❍	❍
Do you smoke or use tobacco of any kind? _____	❍	❍

Doctor's Signature _____

Blood Pressure_____/_____

	Yes	No
Ulcer, colitis _____	❍	❍
Hepatitis, liver disease _____	❍	❍
Kidney trouble, dialysis _____	❍	❍
Thyroid disorder_____	❍	❍
Diabetes _____	❍	❍
How is it controlled? _____		
Long-term steroid therapy _____	❍	❍
Hormone Therapy (incl. birth control pill) _____	❍	❍
Arthritis, rheumatism _____	❍	❍
Eye disorders, glaucoma _____	❍	❍
Fainting spells, epilepsy, convulsions _____	❍	❍
Neurological problems _____	❍	❍
Psychiatric Care_____	❍	❍
Frequent headaches _____	❍	❍
Alcoholism, drug abuse _____	❍	❍
Malignancies_____	❍	❍
Radiation treatments/chemotherapy _____	❍	❍
Venereal disease, Herpes _____	❍	❍
Do you have any reason to believe that you may have been exposed to HIV, the virus that causes AIDS? _____	❍	❍
Are you pregnant? _____	❍	❍
If so, what month? _____		
Do you have any disease, condition, allergy or problem not listed? _____	❍	❍
If so, explain _____		
Have you ever had:		
1. Exposure to a person with tuberculosis _____	❍	❍
2. Tuberculosis _____	❍	❍
3. A positive skin test for tuberculosis _____	❍	❍
4. Have you had a chest x-ray follow up _____	❍	❍
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❍	❍

Name of physician or dentist

_____

Phone: _____

The undersigned agrees that the information above is accurate.

Signature _____ Date_____

HEALTH STATUS CHANGES

Date	Change in Health Status	Blood Pressure	Patient's Signature	Reviewed By
		/		
		/		
		/		
		/		
		/		
		/		
		/		
		/		