Patient Name_____Nickname:_____ Birth date _____

Referred By:

DENTAL HISTORY

I routinely see my dentist every: 3mo. 4mo. 6mo. 12mo. Not routinely

Is there anything about the appearance of your teeth that you would like to change?_____

What is your immediate concern? _____

Do you have or have you had any of the following? (Please check all that apply to you)

- ○ Bleeding gums
- ○ Broken fillings
- ○ Chronic bad breath
- ○ Decayed teeth
- ○ Food catches between teeth
- ○ Grinding or clenching of teeth
- ○ Injury to teeth or jaw
- ○ Loose teeth
- ○ Orthodontic treatment
- ○ Periodontal treatment
- ○ Painful or locking jaw
- ○ Sensitivity to sweet, hot, cold, biting
- ○ Sores, growths or swelling in mouth

Describe: _____ Rate Dental Anxiety (1-10):_____

MEDICAL HISTORY

Do you have or have you had any of the following? (Please check all that apply to you)

- ○ Anemia
- ○ Arthritis, rheumatism
- ○ Artificial heart valves
- ○ Artificial joints
- ○ Asthma, sinus problems
- ○ Autoimmune disease
- ○ Back problems
- ○ Blood disease
- ○ Abnormal bleeding, prolonged healing, bruising easily
- ○ Cancer
- ○ Chemical dependency
- ○ Chemotherapy
- ○ Circulatory problems
- ○ Cortisone treatments/steroids
- ○ Cough, persistent/chronic
- ○ Cough up blood
- ○ Diabetes
- ○ Epilepsy/seizures
- ○ Fainting
- ○ Glaucoma/eye disorders
- ○ Headaches, migraine headaches
- ○ Heart murmur
- ○ Heart disease (describe)
- ○ Taking Birth control
- ○ Hemophilia
- ○ Hepatitis/liver diseases/jaundice
- ○ High blood pressure
- ○ Low blood pressure
- ○ HIV positive
- ○ AIDS
- ○ Kidney disease
- ○ Mitral value prolapse
- ○ Malignancy or tumor/cyst
- ○ Nervous disorders
- ○ Pacemaker
- ○ Psychiatric care
- ○ Radiation treatment to head or neck area
- ○ Respiratory disease
- ○ Rheumatic fever/rheumatic heart disease
- ○ Shortness of breath
- ○ Skin rash
- ○ Stroke
- ○ Congestive heart failure
- ○ Thyroid disease
- ○ Tobacco habit
- ○ Tuberculosis
- ○ Ulcer/digestive disorders
- ○ Venereal disease
- ○ Are you pregnant Or nursing?

Please describe any impending operations, recent injuries or other current conditions not listed above:

_____

Physician_____Tel #_____

Date of last physical exam:_____ Purpose: _____

Please list all medications you are currently taking as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies: _____

_____

_____

_____

_____

_____

Allergies/reactions to medications? _____

Patient signature_____Date_____ Dentist's initials_____