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Dental/Med History

Dental History

Why have you come to the dentist today?	Are your teeth sensitive to heat, cold or anything else?
Are you currently in pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have mobility in your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you require antibiotics before dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have wisdom teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No
Your current dental health? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Previous/ <input type="checkbox"/> Present Dentist _____ Last visit date: _____
Do you floss daily? <input type="checkbox"/> Yes <input type="checkbox"/> No Brush daily? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like fresher breath? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of bristles in your toothbrush? <input type="checkbox"/> Hard <input type="checkbox"/> Med <input type="checkbox"/> Soft	Would you like whiter teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums ever bleed? <input type="checkbox"/> Yes <input type="checkbox"/> No Ever itch? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you happy with the way your smile looks? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had periodontal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what would you change?

Medical History

Do you have a personal physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician's name:	Please explain: _____
Address: _____ City: _____ State: _____ Zip: _____	Have you ever taken Phen-Fen, Redux or Pandimin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone: _____ Date of last visit: _____	For women: Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No
Your current physical health? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Are you pregnant? <input type="checkbox"/> Unsure <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke or use tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No	Week# _____ Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you or have you experienced the following? (check all that apply)

<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Colitis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Shingles
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Congenital heart defect	<input type="checkbox"/> Headaches	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Lupus	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Steroid Therapy
<input type="checkbox"/> Artificial bones/joints	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial valves	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Psychiatric problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Ever hospitalized	<input type="checkbox"/> Herpes	<input type="checkbox"/> Radiation treatment	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Fever blisters	<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Seizures	

Please list any serious medical conditions that you have experienced:

Are you taking any prescription/over the counter <input type="checkbox"/> Yes <input type="checkbox"/> No	Please list: _____
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Are you allergic to any of the following? (check all that apply)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Latex	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Dental anesthetics	<input type="checkbox"/> Jewelry/metals	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Other

Please list anything additional that causes allergic reactions:

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature: _____ Date: _____