

Patient's Name: _____

Dental Health History

Previous Dentist: _____ Date of Last Visit: _____

Previous Dentist Location: _____

Please check statements that apply to you.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Chew on one side | <input type="checkbox"/> Grind | <input type="checkbox"/> Snore | <input type="checkbox"/> Bite your nails |
| <input type="checkbox"/> Drink tea or coffee | <input type="checkbox"/> Smoke | <input type="checkbox"/> Gag easily | <input type="checkbox"/> Floss |
| <input type="checkbox"/> Brush regularly | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Wear partials |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Wear dentures | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Sensitivity |
| <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Orthodontic | <input type="checkbox"/> Swollen gums |
| <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Food trapped in teeth | <input type="checkbox"/> None Apply | |

Anything you want to change about your smile?

- | | | |
|--|---|--|
| <input type="checkbox"/> Make teeth whiter | <input type="checkbox"/> Repair chipped teeth | <input type="checkbox"/> Replace/change stained or silver fillings |
| <input type="checkbox"/> Close a space | <input type="checkbox"/> Nothing | <input type="checkbox"/> Other: _____ |

Medical Health History

Physician: _____ Office Phone: _____

Are you under the care of a doctor? Yes No

Hospitalized in the past 2 years? Yes No

If yes to previous questions, please explain: _____

Have you ever had...? Please check those that apply.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hepatitis ____ | <input type="checkbox"/> Tumor | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Head injuries | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Sinus problem | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mitral valve | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> STDs | <input type="checkbox"/> None apply | |
| <input type="checkbox"/> Other: _____ | | | |

Women Only:

Are you pregnant? Yes No

Taking Birth Control? Yes No

Medications

Have you ever taken the drug fen-phen? Yes No

Are you taking any non-prescription medication(s)? Yes No

Are you taking any prescription medication(s)? Yes No

If yes to any questions, please **provide us a list** or list here.

Allergies

Latex Codeine

Sulfa Penicillin

Iodine **No Allergies**

Other: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health or medication.

Patient/Guardian/Parent's Signature: _____ Date: _____

Dr's Comments: ASA I ASA II ASA III ASA IV Sign: _____ Date: _____ BP measure: _____ Staff Initial: _____

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