Patient Information

Patient Medical History

Name____ Birthdate:___________________

Although dental personnel primary treat the areas in and around your mouth, your mouth is part of your entire body. Health problems you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

	Yes	No
Are you under the care of a Physician now?	☐	☐
Any changes in your health in the past 5 yrs?	☐	☐
Major hospitalization or surgery, last 5 years?	☐	☐
Are you taking medications or drugs?	☐	☐
Serious Head or Neck injuries??	☐	☐
Have you ever taken Fen-Phen or Redux?	☐	☐
Are you on a special diet?	☐	☐
Do you use Tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Do you have a persistent cough? (More than 3 weeks?)	☐	☐
Women:		
Are you pregnant or trying to get pregnant?	☐	☐
Are you taking Oral Contraceptives? ?	☐	☐
Nursing?	☐	☐

Please Explain:
____
____
____
____

Are you Allergic to, or had reactions to any of the following

Local Anesthetic (e.g. Novocaine)	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Sedatives	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Latex Rubber	☐ Yes	☐ No
Other ____________________	☐ Yes	☐ No

Physician's Name: ____________________________

Address: ____________________________________

______________________ Phone:____________

Check Appropriate Box ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Do you have, or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Tuberculosis	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Allergies	☐	☐
Rheumatic Fever	☐	☐	Angina	☐	☐	AIDS of HIV infection	☐	☐
Swollen ankles	☐	☐	Heart Murmur	☐	☐	Thyroid Problem	☐	☐
Fainting/Seizures	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Chest Pains	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Epilepsy/Convulsions	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Joint Replacement	☐	☐	Respiratory Problems	☐	☐
Diabetes	☐	☐	Hepatitis/Jaundice	☐	☐	Mitral Valve Prolapse	☐	☐
Kidney Disease	☐	☐	Ulcers, etc	☐	☐	Other_______________	☐	☐
Emphysema	☐	☐	Stroke	☐	☐			

Patient Dental History

Reason for this visit______________________________ Date of Last Dental Check-up_______________

What was done then?______________________________ How often do you visit the dentist?_____________

Name of previous dentist?__________________________ When was last full set of X-rays? _____________

How often do you brush your teeth? ___________________ How often do you floss your teeth?_____________

	Yes	No
Do your gums bleed while brushing/ flossing??	☐	☐
Are your teeth sensitive to hot or cold?	☐	☐
Sensitive to sweet and sour??	☐	☐
Do your feel pain to any of your teeth?	☐	☐
Do you have sores/lumps in/near your mouth?	☐	☐
Do you have any of the following?		
Clicking?	☐	☐
Pain on the side of your face?	☐	☐
Difficulty in opening/closing?	☐	☐
Difficulty in chewing?	☐	☐
Do you have frequent headaches??	☐	☐
Do you clench or grind your teeth?	☐	☐

	Yes	No
Do you bite or tongue or cheek frequently?	☐	☐
Does food get caught between your teeth?	☐	☐
Have you ever worn an bite plate or guard?	☐	☐
Do you wear dentures or partial dentures?	☐	☐
Have you had orthodontic treatment?	☐	☐
Do you wear dentures or partial dentures?	☐	☐
Have you received oral hygiene instruction regarding the care of your gums?	☐	☐
Are you happy with your smile?	☐	☐

How would your rate it 1-10? ________

How would you like it to look?__________________________
____

Have you ever thought about making your teeth whiter or straighter? Please explain______________________________
____