

## PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

tient Name:			Date:		
	DEN <sup>-</sup>	TAL HE	ALTH HISTORY		
	Yes	No		Yes	N
Are you apprehensive about dental treatment?  Have you had problems with previous dental treatment?  Does food catch between your teeth?  Do you have difficulty chewing your food?  Do you chew your food on only one side of your mouth?  Do you avoid brushing any part of your mouth  because of pain?  Do your gums bleed easily?  Do your gums bleed easily when you floss?  Do your gums feel swollen or tender?  Have you ever noticed slow-healing sores in or  about your mouth?  Are your teeth sensitive?  Do you feel twinges of pain when your teeth come in  contact with:  Hot foods or liquids?  Cold foods or liquids?  Sours?  Sweets?			Do you want straighter teeth?  Are you dissatisfied with the appearance of your teeth?  Do you want whiter teeth?  Do you want comprehensive dental care?  Do you clench or grind your teeth frequently?  Do you have any jaw symptoms or headaches  upon waking in the morning?  Does jaw pain or discomfort affect your appetite,  sleep, daily routine, or other activities?  Do you have pain in the face, cheeks, jaws, joints,  throat, or temples?  Are you able to open your mouth as far as you want?  How often do you brush?  How often do you floss?		
Notes:					

## MEDICAL HEALTH HISTORY: Do you have, or have you had, any of the following?

Heart Problems	Yes	No	Yes Diabetes	No	
Chest Pain					
Shortness of breath			Family history of diabetes		
Blood pressure problem			Tuberculosis or other respiratory disease		
Heart murmur	₋ 🖳		Do you drink alcohol?		
Heart valve problem	닏	닏	If so, how much?		
Taking heart medication	. 님	님	Do you smoke?		
Rheumatic fever history		님	If so, how much?	Ш	
Pacemaker		님			
Artificial heart valve	_⊔	Ш	Hepatitis, jaundice, or liver trouble		
Blood Problems	_		HIV- positive/AIDS		
Easy bruising			HIV- positive/AIDS	Ш	
Frequent nosebleeds			Glaucoma		
Abnormal bleeding		╚	History of head injury	П	
Blood disease (anemia)		닏	History of head injury	Ш	
Ever require a blood transfusion?			Epilepsy or other neurological disease		
Allergy Problems			History of alcohol or drug abuse	П	
Hay fever	- 닏	빝	History of alcohol or drug abuse	ш	
Sinus problems	- 님	닏	Do you have any disease, condition, or problem no	ot listed	
Taking allergy medication		님	previously that you feel we should know about?		
Asthma	. Ш	Ш	If so, please describe:		
Intestinal Problems	- 🔲				
Ulcers					
Weight gain or loss					
Kidney or bladder problems					
D - 7 D 11					
Bone or Joint Problems Back or neck pain			During the past 12 months, have you taken		
			any of the following?	Yes	No
Joint replacement	- Ш		Antibiotics or sulfa drugs		П
(c.g., total hip,phis,or hipfants)			Anticoagulants (e.g., Coumadin)	H	H
Fainting spells, Seizures, or Epilepsy	_Ц	Ц	High blood pressure medicine	Ħ	Ħ
Stroke(s)			Tranquilizers		П
Frequent or severe headaches		Ш	Insulin, Orinase, or similar drug		
Thyroid problems			Aspirin		
Persistent cough or swollen glands	. 🔲		Digitalis or drugs for heart trouble		
Cancer/tumor history			Nitroglycerin		
Premedications required by physician			Cortisone (steroids)		
			Natural remedies		
List medications you are currently taking:			Nonprescription drug/supplements		
			Other		
			Women	Yes	No
Are you allergic, or have you reacted adversely		,	A wa way taking contracentives as		
to any of the following?	Y	'es	No Are you taking contraceptives or other hormones?		
Local anesthetics ("Novocaine")			other normones:		
Penicillin or other antibiotics			Are you pregnant?		
Sulfa drugs			If so, expected delivery date:		
Barbiturates, sedatives, or sleeping pills					
Aspirin, Acetaminophen, or Ibuprofen			Are you nursing?		
Codeine, Demerol, or other narcotics				_	<u>—</u>
Reaction to metals	L	╛			
Latex or rubber dam					
Other			Notes:		
Notes:					
			Patient/Parent Signature:		
D	ato.		Dentist Initial:		