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.

Patient name _____ Date of birth _____ Age _____

Name of your physician _____ Date of last visit to physician _____

Name of previous dentist _____ Date of last visit to dentist _____

MEDICAL HEALTH HISTORY:
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK ANY THAT APPLY.

Heart Problems ❑
- Chest pain ❑
- Shortness of breath ❑
- Blood pressure problem ❑
- Heart murmur ❑
- Heart valve problem ❑
- Taking heart medication ❑
- Rheumatic fever ❑
- Pacemaker ❑
- Artificial heart valve ❑

Blood Problems ❑
- Easy bruising ❑
- Frequent nose bleeds ❑
- Abnormal bleeding ❑
- Blood disease (anemia) ❑

Allergy Problems ❑
- Hay fever ❑
- Sinus problems ❑
- Skin rashes ❑
- Taking allergy medication ❑
- Asthma ❑

Intestinal Problems ❑
- Ulcers ❑
- Weight gain or loss ❑
- Special diet ❑
- Constipation ❑

Bone or Joint Problems ❑
- Arthritis ❑
- Back or neck pain ❑
- Joint replacement (e.g., total hip) ❑

Fainting Spells, Seizures, or Epilepsy ❑

Diabetes ❑
- Urinate more than 6 times a day ❑
- Thirsty or mouth is dry much of the time ❑
- Family history of diabetes ❑

Tuberculosis or other respiratory disease ❑

Cancer/Tumor ❑

Do You Drink? ❑
- If so, how much? _____

Do You Smoke? ❑
- If so, how much? _____

Hepatitis, Jaundice, or Liver Trouble ❑

Herpes ❑

HIV-Positive/AIDS ❑

Glaucoma ❑

Do You Wear Contact Lenses? ❑

Are you allergic or have you reacted adversely to any of the following?

Local anesthetics ("Novocaine") ❑
Penicillin or other antibiotics ❑
Sulfa drugs ❑
Barbiturates, sedatives, or sleeping pills ❑
Aspirin ❑
Codeine ❑
Other ❑

During the past 12 months have you taken any of the following?

Antibiotics or sulfa drugs ❑
Anticoagulants (e.g., Coumadin) ❑
High blood pressure medicine ❑
Tranquilizers ❑
Insulin, Orinase, or similar drug ❑
Aspirin ❑
Digitalis or drugs for heart trouble ❑
Nitroglycerin ❑
Cortisone (steroids) ❑
Other ❑
Other ❑

Women

Are you taking contraceptives or other hormones? ❑
Are you pregnant? ❑
- **If so, expected delivery date:** _____

Have any of your babies weighed more than nine pounds? ❑
Have you reached menopause? ❑
- **If so, do you have any symptoms?** ❑

DENTAL HEALTH HISTORY

Please mark any questions that you would answer "YES":

Are you apprehensive about dental treatment? _____ ❑
Have you had problems with previous dental treatment? _____ ❑
Do you gag easily? _____ ❑
Do you wear dentures? _____ ❑
Does food catch between your teeth? _____ ❑
Do you have difficulty in chewing your food? _____ ❑
Do you chew 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 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 take fluoride supplements? _____ ❑
Are you dissatisfied with the appearance of your teeth? _____ ❑
Do you prefer to save your teeth? _____ ❑
Do you want complete dental care? _____ ❑
How often do you brush? _____ How often do you floss? _____
Does your jaw make noise so that it bothers you or others? _____ ❑
Do you clench or grind your jaws frequently? _____ ❑
Do your jaws ever feel tired? _____ ❑
Does your jaw get stuck so that you can't open freely? _____ ❑
Does it hurt when you chew or open wide to take a bite? _____ ❑
Do you have earaches or pain in front of the ears? _____ ❑
Do you have any jaw symptoms or headaches upon awaking in the morning? _____ ❑
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____ ❑
Do you find jaw pain or discomfort extremely frustrating or depressing? _____ ❑
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____ ❑
Do you have a temporomandibular disorder (TMD, TMJ)? _____ ❑
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____ ❑
Are you unable to open your mouth as far as you want? _____ ❑
Are you aware of an uncomfortable bite? _____ ❑
Have you had a blow to the jaw (trauma)? _____ ❑
Are you a habitual gum-chewer or pipe smoker? _____ ❑
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____ ❑
If so, please describe: _____

_____

_____

Date _____ Signature of Patient _____