

So that we may treat you safely and effectively, please answer all questions fully. Thank you.

Updates:	w/initials
____/____/____	____
____/____/____	____
____/____/____	____
____/____/____	____

Name _____ Age _____ Date of Birth ____/____/____

MEDICAL HISTORY

When was your last physical exam? _____ Reason for exam? _____

Are you seeing a physician at this time? *yes / no* If so, for what? _____

Physician's name: _____ Party to notify in case of emergency: _____

Please list any medications (prescription or non-prescription) you are taking, and what they are for:

Are you allergic, or do you react to anything (drugs, food, etc.)? *yes / no* If so, what?

Do you now, or have you ever had: (check if yes)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Malignancy or tumor |
| <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Pain in chest on exertion | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Contact with AIDS virus | <input type="checkbox"/> Artificial joint |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Do you smoke?
How much? _____ / day |
| <input type="checkbox"/> Heart problems/murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> History of drug or alcohol abuse |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> (female) Is there any chance
you could be pregnant? |
| <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Fatigue easily | <input type="checkbox"/> Nervous disorder/
psychiatric care | |

DENTAL HISTORY

What is your main problem / reason for coming? _____

Who referred you to us? _____ Any concerns about dental treatment? *yes / no*

How do you feel about the condition of your teeth? _____

How do you feel about your past dental experiences? _____

Do you now, or have you ever had: (check if yes)

- | | | |
|--|--|---|
| <input type="checkbox"/> Clicking or popping in jaw joint | <input type="checkbox"/> Regular dental checkups | <input type="checkbox"/> Bridgework or partial dentures |
| <input type="checkbox"/> Clenching or grinding, day or night | <input type="checkbox"/> Any missing teeth | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Pains in or near the ear | <input type="checkbox"/> Toothaches | <input type="checkbox"/> Gum surgery, or non-surgical
treatment (root planing) |
| <input type="checkbox"/> "TMJ" splint, or other types of treatment | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Orthodontic treatment (braces) |
| <input type="checkbox"/> Other sore or painful areas in mouth | <input type="checkbox"/> Pain in chewing | <input type="checkbox"/> Root canal work |
| | <input type="checkbox"/> Canker sores | |

When was your last dental visit? _____ Did you have x-rays at that time? *yes / no*

Have you been instructed on how to brush and floss? *yes / no* If so, when and by whom? _____

How often do you brush? _____ Times per *day / week* When, usually? _____ Type of brush: *hard / soft*

What kind of toothpaste? _____ Do you use dental floss? *yes / no / occasionally*

DIETARY HISTORY

Do you eat or drink between meals during the day? *yes / no* In the evening? *yes / no* Does your diet include:

- | | | | |
|---|---|-------------------------------------|---|
| <input type="checkbox"/> Chewing gum | <input type="checkbox"/> Candy bars | <input type="checkbox"/> Hard candy | <input type="checkbox"/> Soft drinks, soda, fruit juice |
| <input type="checkbox"/> Cookies / pastry | <input type="checkbox"/> Sugar in coffee or tea | <input type="checkbox"/> Lifesavers | <input type="checkbox"/> Breath mints or cough drops |

Thank you for taking the time to complete this form! Today's date: ____/____/____ Signature: _____