# PATIENT INFORMATION

TODAY'S DATE _____

**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 CIRCLE ANY THAT APPLY.**

Heart Problems _____ Y N
- Chest Pain _____ Y N
- Shortness of breath _____ Y N
- Blood pressure problem _____ Y N
- Heart murmur _____ Y N
- Heart valve problem _____ Y N
- Taking heart medication _____ Y N
- Rheumatic fever _____ Y N
- Pacemaker _____ Y N
- Artificial heart valve _____ Y N

Blood Problems _____ Y N
- Easy bruising _____ Y N
- Frequent nose bleeds _____ Y N
- Abnormal bleeding _____ Y N
- Blood disease (anemia) _____ Y N

Allergy Problems _____ Y N
- Hay fever _____ Y N
- Sinus problems _____ Y N
- Skin rashes _____ Y N
- Taking allergy medication _____ Y N
- Asthma _____ Y N

Intestinal Problems _____ Y N
- Ulcers _____ Y N
- Weight gain or loss _____ Y N
- Special diet _____ Y N
- Constipation _____ Y N

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

Fainting Spells, Seizures, or Epilepsy _____ Y N

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

Tuberculosis or other respiratory disease _____ Y N

Cancer/Tumor _____ Y N

Do you use alcohol? _____ Y N
- If so, how often? _____ Y N

Do you smoke or chew tobacco? _____ Y N
- If so, how often? _____ Y N

Hepatitis, Jaundice or Liver Trouble _____ Y N

Herpes _____ Y N

HIV-Positive/AIDS _____ Y N

Glaucoma _____ Y N

Do you Wear Contact Lenses? _____ Y N

Has your Physician Ever Recommended an Antibiotic for Dental Treatment? _____ Y N

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

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

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

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

**Women**

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

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

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# DENTAL HEALTH HISTORY

**Please circle any questions that you would answer "YES" - Please explain:**

Are you apprehensive about dental treatment? Y N
Have you had problems with previous dental treatment? Y N
Do you gag easily? Y N
Do you wear dentures? Y N
Does food catch between your teeth? Y N
Do you have difficulty in chewing your food? Y N
Do you chew on only one side of your mouth? Y N
Do you avoid brushing any part of your mouth because of pain? Y N
Do your gums bleed easily? Y N
Do your gums bleed when you floss? Y N
Do your gums feel swollen or tender? Y N
Have you ever noticed slow healing sores in or about your mouth? Y N
Are your teeth sensitive? Y N

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids? Y N
Cold foods or liquids? Y N
Sours? Y N
Sweets? Y N

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

If so, please describe:

Date Signature of Patient