

PERSONAL DENTAL HISTORY

General/Restorative Dentist:

Date of last cleaning:

Reason you were referred to our office:

Have you ever Periodontal Treatment (deep cleanings, gum grafting, etc.): If yes, please explain.

Have you ever had Orthodontic work (braces, retainers, etc.): If yes, please explain.

What is your daily hygiene routine:

Brush	_____ time's daily	<input type="checkbox"/> Manual	<input type="checkbox"/> Electric	Mouthrinse	_____ time's	<input type="checkbox"/> daily	<input type="checkbox"/> weekly
Floss	_____ time's	<input type="checkbox"/> daily	<input type="checkbox"/> weekly				

PERSONAL HEALTH HISTORY

Physician:

Date of last physical exam:

Allergies

No Allergies Antibiotics _____ Demerol Latex/Tape
 Novocain Other: _____

Conditions

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Artificial Joint Where _____ When _____
<input type="checkbox"/> Symptomatic Mitral Valve Prolapse	If yes, Do you Antibiotic Pre-Med <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Artificial Valve When _____	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Angina	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Pacemaker When _____ Location: <u>Left/Right</u>	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Attack When _____	<input type="checkbox"/> Hepatitis Type _____ Active? _____
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Pregnant How far along _____ mths
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> TB <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema
<input type="checkbox"/> Stroke When _____	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Bleed Excessively	<input type="checkbox"/> High risk for HIV/Aids

Tobacco: Do you smoke _____ Cigs. per day _____ # of years Chew _____ per day Pipe _____ per day

Are you under ongoing care with a physician? Yes No Why _____

Surgeries within the last 5 years

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.