Dr. Hurtado
DENTISTRY

Name: _____ Gender Female ☐ Male ☐ Date of Birth _____ Age _____
First Last M/D/Y
Date of last dental exam _____ Date of last X-rays _____ Do you have any discomfort? SI NO

What is the reason for your visit today? _____

Dental History

27.

1. YES NO Do you brush teeth at least twice a day?
2. YES NO Do you floss your teeth at least once a day?
3. YES NO Have you seen a dentist recently?
4. YES NO Have you had problems with prior dental treatment?
5. YES NO Do you have sores or swelling in your mouth?
6. YES NO Do you use any tobacco products?
7. YES NO Do you drink tea, coffee, dark soft drinks or wine?
8. YES NO Are you interested in a brighter smile?
9. YES NO Would you like straighter teeth?
10. YES NO Have you ever had orthodontic treatment?
11. YES NO Have you ever had whitening treatment?
12. YES NO Do you like the way your teeth look?
13. YES NO Have you ever had any problems with prior dental treatment before?
14. YES NO Do you grind your teeth at night?

Medical/ Physician Information

Do you have a physician or medical clinic? YES ☐ NO ☐

Name of your physician or clinic _____

Telephone number of physician or clinic _____

Date of last medical exam _____

15. YES NO Is your general health good?
16. YES NO Are you being treated by a physician now?
    Please specify _____
17. YES NO Has there been a change in your health this year?
18. YES NO Are you currently under great personal stress?
19. YES NO Have you been hospitalized or had a serious illness or psychiatric care in the last three years?

Have you experienced recently?

20. YES NO Chest pain?
21. YES NO Bleeding problems or brusing easily?
22. YES NO Frequent vomiting or nausea?
23. YES NO Seizures?
24. YES NO Difficulty swallowing, excessive thirst or dry mouth?
25. YES NO Do you have limited mouth opening?
26. YES NO Have you ever broken your jaw?

Are you taking?

27. YES NO Aspirin or blood thinners?
28. YES NO Drugs, medications, over-the-counter medicines?
    Please list: _____
    _____

Do you have now or do you have history with?

29. YES NO Allergy to Penicillin or Amoxicillin?
30. YES NO Allergies to any other drugs or medications?
    Please specify: _____
31. YES NO Allergy to latex?
32. YES NO High Blood pressure?
33. YES NO Heart disease of arteries or stroke?
34. YES NO Heart murmurs?
35. YES NO Diabetes?
36. YES NO Hepatitis?
37. YES NO Other liver disease?
    Type? _____
38. YES NO Radiation or chemotherapy for cancer?
39. YES NO Bis-phosphonate or osteoporosis treatment?
40. YES NO Kidney or bladder disease?
41. YES NO Stomach problems or ulcers?
42. YES NO Skin or eye disease?
43. YES NO Tuberculosis or emphysema?
44. YES NO VD (syphilis or gonorrhea)?
45. YES NO AIDS o HIV+?
46. YES NO Drug or alcohol abuse?
47. YES NO Pacemaker or artificial joint?
48. YES NO Any other diseases or medical problems not listed on this form?
    _____

Women only

49. YES NO Are you or could you be pregnant?
50. YES NO Are you nursing a baby?
51. YES NO Are you taking birth control pills?

Patient or Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____