Although dental personnel primarily treat the area in and around your mouth, it is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's name: ____

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please list: ______________________

____

Have you ever been told you needed to take antibiotics (pre-medication) prior to a dental visit? ☐ Yes ☐ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: ______________________

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: ______________________

Have you ever used tobacco? ☐ Yes ☐ No If yes, please explain: ______________________

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: ______________________

WOMEN: Are you: Taking oral contraceptives ☐ Yes ☐ No Pregnant/Trying to get pregnant ☐ Yes ☐ No Nursing ☐ Yes ☐ No

Are you allergic to any of the following?

Aspirin	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No	Codeine	☐ Yes ☐ No	Acrylic	☐ Yes ☐ No
Metal	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Local Anesthetics	☐ Yes ☐ No		
Other	☐ Yes ☐ No	If other, please explain: ______________________					

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Sores/Fever Blisters	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:______________________

____

Please Answer Each Question

Date of last dental visit? ____________________ Last dental cleaning? ___________________ Last full mouth x-rays:_________________________

What was done at your last dental visit? ____

Previous Dentist name: ____

Reason for leaving: ____

How Often Do You Brush? _____________________________________ Toothpaste: ____

How Often Do You Floss? _____________________________________ Mouthwash: ____

Please Indicate an Answer For Each History Question

Are your teeth sensitive to:

Hot or Cold	☐ Yes	☐ No
Biting/Chewing	☐ Yes	☐ No
Sweets	☐ Yes	☐ No

Have you ever had:

Orthodontic treatment	☐ Yes	☐ No	A bite plate or guard	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Serious injury to mouth/head	☐ Yes	☐ No			

Comments: ____

____

Please Indicate an Answer For Each Behavior / Habits Question

Clench/Grind Teeth	☐ Yes	☐ No	Bulimia/Anorexia	☐ Yes	☐ No	Suck Thumb/Finger	☐ Yes	☐ No
Bite Cheek	☐ Yes	☐ No	Cigar/Cigarette	☐ Yes	☐ No	Toothpick/Stimulator	☐ Yes	☐ No
Tobacco	☐ Yes	☐ No	Chewing Tobacco	☐ Yes	☐ No	Chewing Gum	☐ Yes	☐ No
Tongue Thrust	☐ Yes	☐ No	Bite Nails	☐ Yes	☐ No	Candy	☐ Yes	☐ No
Mouth Breather	☐ Yes	☐ No	Pipe	☐ Yes	☐ No	Soft Drinks	☐ Yes	☐ No

Other: ____

Comments: ____

____

____

Please Answer Each TMJ Question

History of clenching/grinding ☐ Yes ☐ No If yes, 1st date noticed: ______________________ Treatment rendered: _______________

TMJ popping and clicking ☐ Yes ☐ No If yes, for how long: ____

(The TMJ is the connecting hinge between the lower jaw and base of the skull)

History of joint dislocation ☐ Yes ☐ No If yes, date of initial dislocation: _______________ Number of times: _________________

History/trauma to head/neck ☐ Yes ☐ No If yes, please explain: ____

Comments: ____

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(Please turn the page for information about our office policies)