



Name: \_\_\_\_\_

BP: \_\_\_\_\_

/

P

Date \_\_\_\_\_

---(Above for office use only)-----

Do you currently have bleeding gums? \_\_\_\_\_ Does food wedge between your teeth? \_\_\_\_\_ Where? \_\_\_\_\_  
 Do you clench or grind your teeth? \_\_\_\_\_ When? \_\_\_\_\_ Are there any lumps or swelling in your mouth? \_\_\_\_\_  
 Have you had your teeth straightened? \_\_\_\_\_ When? \_\_\_\_\_ Have you had wisdom teeth extracted? \_\_\_\_\_  
 Any pain in or around your ears? \_\_\_\_\_ Do you hear popping, clicking or snapping when you chew? \_\_\_\_\_  
 Do you have any fear of dental treatment? None \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_  
 Are you comfortable having dental treatment with only local anesthetic? \_\_\_\_\_  
 Do you require Antibiotics before Dental Treatment?  Yes  No

**Dental History: Esthetic**

Are your teeth: Chipped?  Protruding?  Hidden?  Discolored?  Crooked?  Large Spaces?   
 Do you like the shape of your teeth? \_\_\_\_\_ Are there any fillings, caps you don't like looking at? \_\_\_\_\_  
 Do You Like Your Smile? \_\_\_\_\_ If not, why? \_\_\_\_\_

**Medical History:**

Physician's Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_ For what? \_\_\_\_\_

Are You Taking Any Medications Prescribed by a Physician? (Y) (N) What medications and how much?

\_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to any medications or substances? (Y) (N) List please \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Do you have any of the following?: (Please indicate YES with a check mark)**

Any Heart Disease	<input type="checkbox"/>	Allergies to medicines or drug:	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	Do you SMOKE or dip snuff?	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	How much?		Fainting or Dizzy Spells	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Typhoid Fever	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>
Nervous Problems	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Radiation Treatments	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	AIDS or HIV pos	<input type="checkbox"/>	Are You Pregnant?	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Malignancies (Cancer)	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	What kind?		Thyroid Disease	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	Surgery requiring general ane:	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>

**Medical Updates:**

Date \_\_\_\_\_ Changes? \_\_\_\_\_

Date \_\_\_\_\_ Changes? \_\_\_\_\_

Date \_\_\_\_\_ Changes? \_\_\_\_\_

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