

DENTAL HISTORY

(WE NEED THE FOLLOWING **CONFIDENTIAL** HEALTH INFORMATION ABOUT THE PATIENT)

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|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
1. HAVE YOU COME TO THIS OFFICE FOR PAIN RELIEF?
 IF YES, HOW LONG HAS IT HURT? _____
 WHERE IS THE PAIN? _____
 HOW DOES IT HURT? WITH:
 HOT COLD SWEETS CONSTANTLY
 2. HOW LONG SINCE YOU'VE BEEN TO A DENTIST? _____
 3. HOW OFTEN DID YOU VISIT A DENTIST BEFORE THEN?
 REGULAR, EVERY 6 MONTHS IRREGULAR
 REGULAR, EVERY YEAR ALMOST NEVER
 4. WHEN WAS YOUR LAST SET OF FULL MOUTH X-RAYS? _____
 5. HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUM DISEASE)?
 6. HOW OFTEN DO YOU BRUSH YOUR TEETH? _____
 7. PLEASE CHECK ANY ITEMS BELOW THAT YOU USE OFTEN IN ORAL CARE:
 HAND TOOTH BRUSH ELECTRIC TOOTH BRUSH
 DENTAL FLOSS GUM STIMULATORS
 RUBBER TIPS WATER SPRAY (WATER-PIC)
 8. DO YOUR GUMS BLEED WHEN YOU BRUSH?.....
 9. HAVE YOU EVER HAD YOUR TEETH STRAIGHTENED?
 10. HAVE YOU EVER HAD ANY INJURY TO YOUR FACE OR JAWS?
 IF YES, EXPLAIN _____
 11. HAVE YOU EVER HAD A CLICKING OR POPPING NEAR YOUR EAR WHEN YOU CHEW?.....
 12. DO YOU GRIND YOUR TEETH?.....

- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
13. DO YOU HAVE SORES, BLISTERS OR SWELLING ON YOUR GUMS, LIPS OR CHEEKS?
 IF YES, HOW LONG HAVE THEY BEEN PRESENT? _____
 WHERE ARE THEY? _____
 14. HAVE YOU EVER LOST ANY PERMANENT TEETH?.....
 IF YES, FOR WHAT REASON?
 DECAY GUM DISEASE INJURY OTHER
 15. HAVE YOU EVER HAD ANY COMPLICATIONS FROM AN EXTRACTION?.....
 IF YES, PLEASE EXPLAIN _____

IF YOU CAME TO THIS OFFICE FOR A NEW DENTURE, COMPLETE THE FOLLOWING PORTION:

16. WHEN WERE YOUR NATURAL TEETH REMOVED? _____
17. HOW MANY SETS OF DENTURES HAVE YOU HAD? _____
18. WHEN WERE YOUR PRESENT DENTURES CONSTRUCTED? _____
19. DO YOU LIKE THE APPEARANCE OF YOUR PRESENT SET OF DENTURES?.....
20. HAS YOUR PRESENT SET OF DENTURES EVER BEEN RELINED OR REBASED?.....

IF PATIENT IS A CHILD, PLEASE ANSWER THE FOLLOWING QUESTIONS:

21. PLEASE CHECK ANY OF THE FOLLOWING HABITS THE CHILD HAS:
 THUMBSUCKING NAILBITING
 MOUTHBREATHING UNUSUAL SPEECH PATTERNS
22. DO YOU RECEIVE FLUORIDE IN
 VITAMINS TABLETS WATER.....

MEDICAL HISTORY

- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
1. HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH? POOR FAIR GOOD EXCELLENT
 2. ARE YOU NOW BEING TREATED OR HAVE YOU BEEN TREATED IN THE LAST YEAR BY A PHYSICIAN?
 IF YES, FOR WHAT CONDITION? _____
 3. DATE OF LAST MEDICAL EXAMINATION _____
 4. NAME OF YOUR PHYSICIAN _____
 5. HAVE YOU BEEN TAKING ANY MEDICINES OR DRUGS IN THE PAST YEAR?
 IF YES, PLEASE LIST: _____
 6. HAVE YOU BECOME SICK FROM, SHOWN ALLERGY TO, OR BEEN TOLD NOT TO TAKE: ANTIBIOTICS (PENICILLIN) CODEINE OR NARCOTICS ANESTHESIA (NOVOCAINE, ETC.) OTHER _____
 7. DO YOU WEAR A CARDIAC PACEMAKER?
 8. WOMEN - ARE YOU PREGNANT AT THIS TIME?
 9. HAVE YOU EVER HAD ANY OF THE FOLLOWING: (PLEASE CHECK)

<input type="checkbox"/> ANEMIA	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> TIGHTNESS IN CHEST	<input type="checkbox"/> DIFFICULTY SWALLOWING	<input type="checkbox"/> CHEMOTHERAPY (CANCER, LEUKEMIA)
<input type="checkbox"/> STROKE	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> MENTAL DISORDERS	<input type="checkbox"/> FREQUENT HEADACHES	<input type="checkbox"/> PSYCHIATRIC TREATMENT	<input type="checkbox"/> HISTORY OF DIABETES IN YOUR FAMILY
<input type="checkbox"/> DIABETES	<input type="checkbox"/> BLOOD DISEASE	<input type="checkbox"/> PERSISTENT COUGH	<input type="checkbox"/> ASTHMA OR HAY FEVER	<input type="checkbox"/> X-RAY OR COBALT TREATMENT	<input type="checkbox"/> ARTHRITIS OR PAINFUL SWOLLEN JOINTS
<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> TUMORS OR ULCERS	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> CONTINUAL THIRSTY FEELING	<input type="checkbox"/> SHORTNESS OF BREATH ON MILD EXERTION
<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> HEART SURGERY	<input type="checkbox"/> JOINT REPLACEMENT	<input type="checkbox"/> RESPIRATORY DISEASE	<input type="checkbox"/> JAUNDICE OR LIVER DISEASE	<input type="checkbox"/> KIDNEY OR BLADDER DISEASE OR INFECTION
<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> SINUS TROUBLE	<input type="checkbox"/> ALLERGIES OR HIVES	<input type="checkbox"/> ARTIFICIAL PROSTHESIS	<input type="checkbox"/> SWELLING IN ANKLES OR FEET	<input type="checkbox"/> ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)
<input type="checkbox"/> COLD SORES	<input type="checkbox"/> DRUG ADDICTION	<input type="checkbox"/> DRY BURNING MOUTH	<input type="checkbox"/> AIDS RELATED COMPLEX	<input type="checkbox"/> FAINTING SPELLS, CONVULSIONS	<input type="checkbox"/> VENEREAL DISEASE (HERPES, SYPHILIS, GONORRHEA)
 10. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM YOU THINK I SHOULD KNOW ABOUT: IF SO PLEASE EXPLAIN _____

I CONFIRM AS TRUE THE ABOVE HEALTH INFORMATION: SIGNATURE _____ DATE _____

CHANGES IN HEALTH _____ DATE _____