DENTAL HISTORY

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

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

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

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

	Yes	No
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?	O	O
20. HAS YOUR PRESENT SET OF DENTURES EVER BEEN RELINED OR REBASED?	O	O

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

21. PLEASE CHECK ANY OF THE FOLLOWING HABITS THE CHILD HAS:
    O THUMB SUCKING O NAIL BITING
    O MOUTH BREATHING O UNUSUAL SPEECH PATTERNS
22. DO YOU RECEIVE FLUORIDE IN
    O VITAMINS O TABLETS O WATER O O

MEDICAL HISTORY UPDATE

	Yes	No
1. DO YOU REQUIRE PRE-MEDICATION FOR DENTAL TREATMENT?	O	O
2. HAVE YOU EVER BEEN TESTED FOR HIV?	O	O
3. HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH?		
O POOR O FAIR O GOOD O EXCELLENT		
4. ARE YOU NOW BEING TREATED OR HAVE YOU BEEN TREATED IN THE LAST YEAR BY A PHYSICIAN?	O	O
IF YES, FOR WHAT CONDITION? _____		
5. DATE OF LAST MEDICAL EXAMINATION _____		
6. NAME OF YOUR PHYSICIAN _____		
7. HAVE YOU BEEN TAKING ANY MEDICINES OR DRUGS IN THE PAST YEAR?	O	O
IF YES, PLEASE LIST: _____		
_____		
8. HAVE YOU BECOME SICK FROM, SHOWN ALLERGY TO OR BEEN TOLD NOT TO TAKE:		
O ANTIBIOTICS (PENICILLIN) O CODEINE OR NARCOTICS		
O ANESTHESIA (NOVOCAINE, ETC.) O OTHER		
9. DO YOU WEAR A CARDIAC PACEMAKER?	O	O
10. WOMEN–ARE YOU PREGNANT AT THIS TIME?	O	O
11. HAVE YOU EVER HAD ANY OF THE FOLLOWING: (PLEASE CHECK)		
O HEART DISEASE O HEART SURGERY		
O RHEUMATIC FEVER O HEART MURMUR		
O SHORTNESS OF BREATH ON MILD EXERTION	O SWELLING IN ANKLES OR FEET	
O TIGHTNESS IN CHEST	O HIGH BLOOD PRESSURE	
O FREQUENT HEADACHES	O FAINTING SPELLS, CONVULSIONS	
O EPILEPSY		
O TUBERCULOSIS	O MENTAL DISORDERS	
O PERSISTENT COUGH	O EMPHYSEMA	
O HISTORY OF DIABETES IN YOUR FAMILY	O ASTHMA OR HAY FEVER	
	O CONTINUAL THIRSTY FEELING	
O DIABETES	O DRY, BURNING MOUTH	
O HEPATITIS	O JAUNDICE OR LIVER DISEASE	
O KIDNEY OR BLADDER DISEASE OR INFECTION	O ARTHRITIS OR PAINFUL SWOLLEN JOINTS	
O ANEMIA	O BLOOD DISEASE	
O EXCESSIVE BLEEDING REQUIRING TREATMENT	O VENEREAL DISEASE (HERPES, SYPHILIS, GONORRHEA)	
O TUMORS OR ULCERS	O X-RAY, COBALT TREATMENT	

12. 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 _____