ADVANCED FAMILY DENTAL CARE

Dental History

Patient Name _____

Reason for Today's Visit_____ Date of Last Dental Care _____/_____/_____

Former Dentist_____ Date of Last Dental X-rays_____/_____/_____

Are you happy with your smile? ☐ Yes ☐ No Did you have Orthodontic treatment? ☐ Yes ☐ No

Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Difficult extractions	☐ Loose teeth or broken fillings	☐ Sensitivity to hot
☐ Bleeding gums	☐ Food collection between the teeth	☐ Missing teeth	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Grinding or clenching teeth	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Difficulty chewing	☐ Ill-fitting dentures	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name_____ Date of Last Visit _____

Are you taking or scheduled to begin taking Bisphosphonates for the treatment of osteoporosis, Paget's disease or complications from cancer? (e.g. Actonel, Aredia, Boniva, Fosamax, Zometa) ☐ Yes ☐ No

Have you any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates _____

Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken Fen-phen/Redux? ☐ Yes ☐ No

(Women)

Are you pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had problems with any of the following:

☐ Anemia	☐ Circulatory Problems	☐ Hepatitis, Jaundice, Liver Disease	☐ Sinus Trouble
☐ Angina or Chest Pain	☐ Congenital Heart Lesions	☐ High Blood Pressure	☐ Skin Rash
☐ Arthritis, Rheumatism	☐ Cortisone Treatments	☐ HIV.AIDS	☐ Sleep Disorders, Snoring
☐ Artificial Heart Valve	☐ Cough Persistent or Bloody	☐ Infective Endocarditis	☐ Stroke
☐ Artificial Joints, Pins, etc.	☐ Diabetes (Type I or II)	☐ Jaw Pain	☐ Swelling of Feet or Ankles
☐ Asthma	☐ Eating Disorder	☐ Kidney Disease	☐ Systematic Lupus Erythematosus
☐ Auto Immune Disease	☐ Epilepsy or Seizures	☐ Low Blood Sugar	☐ Thyroid Problems
☐ Back Problems	☐ Fainting	☐ Mental Health Disorders	☐ Tobacco Habit
☐ Bleeding Abnormality	☐ Glaucoma	☐ Pacemaker	☐ Tuberculosis
☐ Blood Disease	☐ Headaches	☐ Radiation Treatment	☐ Ulcer or Gastrointestinal Disease
☐ Cancer	☐ Heart Murmur	☐ Respiratory Disease (e.g. COPD)	☐ Other_____
☐ Controlled Substance Use	☐ Heart Problems	☐ Rheumatic Fever	☐ Other_____
☐ Chemotherapy	☐ Heart Transplant	☐ Sexually Transmitted Diseases	
☐ Chronic Pain	☐ Hemophilia	☐ Shortness of Breath	

List medications you are currently taking and the correlating Diagnosis:

_____

_____

_____

_____

_____

Allergies: (e.g. Latex, Drugs, Local Anesthesia, Antibiotics, other)

_____

_____

_____

_____

_____

X_____ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date | Relationship to Patient

OFFICE USE ONLY:

_____ _____ _____/_____/_____

Doctor's Name (Print) | Doctor's Signature | Date