



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:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Difficult extractions | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Ill-fitting dentures | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> 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:

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

List medications you are currently taking and the correlating Diagnosis: _____ Allergies: (e.g. Latex, Drugs, Local Anesthesia, Antibiotics, other) _____

_____	_____
_____	_____
_____	_____
_____	_____

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

OFFICE USE ONLY:		
_____	_____	____/____/____
Doctor's Name (Print)	Doctor's Signature	Date