DENTAL & MEDICAL INFORMATION

Name: ____________________

What is the reason for your dental visit today? ____________________

Date of last exam: ____ / ____ / ____ What was done at that time? ____________________

Name of previous dentist: ____________________

Have you had any problems associated with previous dental treatment? No If yes, please list:

____

Do you or have you had any of the following?

Bleeding, sore gums	Y N		Dry mouth	Y N
Teeth sensitive to cold/hot, sweets, pressure	Y N		Difficulty opening or closing jaw	Y N
Unpleasant taste/bad breath	Y N		Brux or grind teeth	Y N
Frequent sores, ulcers in mouth/lips	Y N		Have you had any past periodontal (gum) treatments?	Y N
Swelling/lumps in mouth	Y N		Ever had orthodontic (braces) treatment?	Y N
Loose Teeth	Y N		Ever had a serious injury to your head or mouth?	Y N
Currently experiencing pain or discomfort	Y N		Are you happy with your smile?	Y N
Earaches or neck pains	Y N		Are you interested in improving your smile?	Y N
Clicking, popping, or discomfort in the jaw	Y N		Are you interested in whitening?	Y N

Are you now under the care of a physician? Y N Date of last physical exam: ____ / ____ / ____

Physician Name: ____________________ Location: ____________________

What is your general state of health? Excellent Good Fair Poor

If female: Are you pregnant or nursing? Y N

Has there been any change in your general health within the last year? Y N

If yes, what condition is being treated? ____________________

Have you had any major surgeries or illnesses in the past 5 years? Y N

If yes, what was the illness or problem? ____________________

Do you or have you had any of the following?

Epilepsy or Seizures	Y N	Chest Pain / Angina	Y N	Cancer	Y N
Fainting or Dizziness	Y N	High Blood Pressure	Y N	Type: ____________	
Emphysema / Bronchitis	Y N	Irregular Heart Beat	Y N	Chemotherapy	Y N
Tuberculosis / PPD+	Y N	Rheumatic Fever	Y N	Radiation Therapy	Y N
Asthma	Y N	Heart Murmur	Y N	Thyroid Disease	Y N
Sinus Problems	Y N	Mitral Valve Prolapse	Y N	AIDS / HIV+	Y N
Bleeding / Blood Disorder	Y N	Congenital Heart Lesions	Y N	Arthritis	Y N
Bruise / Bleed Easily	Y N	Heart Surgery	Y N	Artificial Joints	Y N
Hepatitis A, B, C	Y N	Artificial Heart Valves	Y N	Diabetes	Y N
Liver Disease	Y N	Pacemaker	Y N	Organ Transplants	Y N
Pneumonia	Y N	Stroke	Y N	Osteoporosis / Penia	Y N
Nervousness / Anxious	Y N	**Allergies:**		Snoring	Y N
Kidney Problems	Y N	Penicillin	Y N	Sleep Apnea	Y N
Heart Problem	Y N	Clindamycin	Y N	Tobacco Use	Y N
		Other: ____________		Interested in quitting?	Y N

Do you have any condition, disease, or problem not previously listed? ____________________

List all prescription or over the counter medicines, vitamins, natural or herbal preparations, and/or dietary supplements:

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Patient Signature, Date: ____________________ Dentist Signature, Date: ____________________