DENTAL History

Patient Name: _____ Date_____

Last Dental Visit_____ How often does patient brush per day?_____ floss per day?_____

Have you experienced any of the following: No____ Yes____ If yes, please circle all that apply: bad breath blister on lips/mouth nail biting grinding teeth lip/cheek biting loose/broken fillings ortho treatments pain around ear gum treatments tooth pain sensitivity to hot/cold/sweets sensitivity when biting frequent headaches jaw/head/neck injuries jaw difficulty

Any handicap/disability interfering with oral care (please explain)_____

Any other dental history comments?_____

MEDICAL History

Physician's Name_____ Date of Last Visit_____

Have you had any allergic reaction to the following? No____ Yes____ If yes, please circle ALL that apply: antibiotics local anesthetics sulfa drugs sleeping pills iodine sedatives aspirin latex pain killers Other_____

Please circle ALL medications that you are currently taking: antibiotics high blood pressure medicines osteoporosis medications steroids tranquilizers insulin oral anti-diabetic drugs heart drugs

Please list any other medications (prescription, over-the-counter or herbal) that you are taking:

_____

If you are not taking any current or daily medications (prescribed or over-the-counter), please indicated by circling: NONE

Are you currently taking any blood thinners or anticoagulants? No____ Yes____ If yes, please identify by circling: coumadin plavix daily aspirin heparin other_____

Have you experienced in the past any abnormal bleeding with extractions or other dental procedures? No____ Yes____ If yes, please explain:_____

If you have a history of any of the following, an antibiotic is needed prior to dental cleanings, extractions. **Please circle any of the following medical concerns that apply to you:** artificial heart valves artificial joints within last 2 years history of heart murmur rheumatic fever/rheumatic heart disease mitral valve prolapsed with regurgitation heart valve diseases.

Please circle if you are: pregnant nursing taking birth control pill/patch other_____

Please circle all that apply: smoke currently undergoing medical treatment recent serious illness/operation wear artificial eye lenses use alcohol or other drugs AIDS/HIV anemia arthritis rheumatism asthma back problems blood disease radiation therapy/cancer chemical dependency chemotherapy circulatory problems congenital heart lesions cortisone treatments cardiovascular disease diabetes epilepsy jaundice persistent/bloody cough emphysema fainting/dizziness glaucoma herpes skin rash hepatitis hemophilia jaw pain/jaw problems kidney/liver problems high/low blood pressure nervous problems pacemaker psychiatric care respiratory disease sinus trouble scarlet fever shortness of breath stroke swelling of feet/ankles swollen neck glands thyroid problems tonsillitis tuberculosis tumors ulcer venereal disease.

Do you need to discuss personally with the dentist a medical/dental concern: Please circle: Yes No

I have reviewed the above medical history and it is accurate. Please sign:_____