

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male/Female: \_\_\_\_\_

## Dental History

Dentist: \_\_\_\_\_ Last Visit: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for your visit today: \_\_\_\_\_

	Yes	No
Does the patient need to be pre-medicated for routine dental procedures? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient having dental problems at this time? If so, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any injuries to the teeth or head? Details: _____	<input type="checkbox"/>	<input type="checkbox"/>
Any unfavorable dental experience? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever seen an orthodontist? Result: _____	<input type="checkbox"/>	<input type="checkbox"/>
Is there tooth any sensitivity to temperature or pressure? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any type of thumb or tongue habit? _____	<input type="checkbox"/>	<input type="checkbox"/>
Mouth breather? _____	<input type="checkbox"/>	<input type="checkbox"/>
Jaws or teeth sore in the morning? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does jaw click or pop? _____	<input type="checkbox"/>	<input type="checkbox"/>
Experience "tension" headaches? _____	<input type="checkbox"/>	<input type="checkbox"/>

## Medical History

Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

	Yes	No
Is the patient under any Medical Treatment now? If so, for what condition? _____	<input type="checkbox"/>	<input type="checkbox"/>
Currently take any medications? List: _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever been hospitalized? Reasons & dates: _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever had any serious head injury? Details: _____	<input type="checkbox"/>	<input type="checkbox"/>
Any allergies?.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Pain Medication <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Aspirin <input type="checkbox"/> Latex <input type="checkbox"/> Other _____		

If the patient is a minor, are immunizations up-to-date?  Yes  No  Not Applicable

Does the patient have any of the following conditions?

<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Defects at Birth
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Measles	<input type="checkbox"/> Asthma	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> AIDS Related Complex
<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Tumor/Growths	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Other _____
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Arthritis/Joint Pain	<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Liver Disease	_____

Is there any other Medical or Dental information that you feel we should know about? (Use Back if Needed)

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