Print Form

ERIC L. FUGIER, D.D.S., D.S.O, N.D.

Aesthetic, Prosthetic, Implant and Laser Dentistry

DENTAL HISTORY

CIRCLE

1) Why are you seeking dental treatment?

_____

3) Have you ever had any complication resulting from any dental treatment? Yes No
If yes, please explain _____

_____

3) Have you ever had any complications or allergies with dental anesthetic? Yes No
4) Do you need to be pre medicated before treatment? Yes No
5) Are your teeth: (please circle what apply)
sensitive to heat, cold, sweets, biting, loose?
6) Do you have difficulty in chewing your food? Yes No
7) Do you have difficulty in opening or closing your mouth? Yes No
8) Have you ever been treated or diagnosed for TMD or TMJ? Yes No
9) Do you have pain in your ears or frequent headaches? Yes No
10) Have you ever had orthodontics treatment (braces)? Yes No
11) Have you ever had gum treatment or perio surgery? Yes No
12) Have you ever had implants, bone grafts or Sinus lifts? Yes No
13) Have you noticed spaces developing between your teeth? Yes No
14) Does food wedge between your teeth? Yes No
15) Are you aware of any swelling or lump in your mouth? Yes No
16) Do you have cold sores in the mouth or lips that are slow to heal? Yes No
17) Do you have a persistent bad breath problem? Yes No
18) Did you ever have a bad experience with dentistry before? If yes, please explain?

_____

_____

19) Do you feel nervous about receiving dental treatment? Yes No
20) Are you interested in a lifetime strategy for dental health? Yes No
21) Do you believe in preventive dentistry? Yes No
22) Are you satisfied with the appearance of your teeth or smile? Yes No
23) What are your dental goals? _____

_____

_____

24) Is there anything else important about your medical or dental history that I should know about? If yes, please explain _____

_____

_____

(Please complete both sides)

HEALTH HISTORY

		CIRCLE
1)	Are you in good health now?	Yes No
2)	Are you now under the care of a physician?	Yes No
	If yes, What is the condition being treated? _____	
3)	Have you ever been hospitalized or had a serious illness?	Yes No
4)	Are you taking any MEDICATION now? If yes, please list all and the dosage.	
	1. _____	
	2. _____	
5)	Do you smoke or use tobacco? If yes, how much? _____	
6)	Do you use alcoholic beverages (more than 2 drinks a day)?	Yes No
7)	Have you been treated for any drug addiction?	Yes No
8)	Do you take any antidepressants or tranquilizers?	Yes No
9)	WOMEN: Are you pregnant? Yes No Are you nursing?	Yes No
		Yes No

10) Are you **ALLERGIC** or have you ever experienced a **REACTION** to any of the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	❑	❑	Aspirin or codeine	❑	❑
Barbiturates/sedatives/sleeping pills	❑	❑	Sulfa drugs	❑	❑
Penicillin/other antibiotics	❑	❑	Other allergies _____		

11) Do you **HAVE** or ever **HAD** any of the following? Please check all that apply:

Aids ❑	Emphysema ❑	Pacemaker ❑
Anemia ❑	Epilepsy ❑	Psychiatric care ❑
Arthritis, Rheumatism ❑	Fainting or Dizziness ❑	Radiation Treatment ❑
Artificial Heart Valves ❑	Glaucoma ❑	Respiratory Disease ❑
Artificial Joints ❑	Headaches ❑	Rheumatic Fever ❑
Asthma ❑	Heart Murmur ❑	Scarlet Fever ❑
Back Problems ❑	Heart Problems ❑	Shortness of Breath ❑
Bleeding abnormally,. ❑	Hepatitis type____ ❑	Sinus Trouble ❑
with extractions or surgery ❑	Herpes ❑	Skin Rash ❑
Blood Disease ❑	High Blood Pressure ❑	Stroke ❑
Cancer ❑	HIV Positive ❑	Swelling of Feet/Ankles ❑
Chemical Dependency ❑	Jaundice ❑	Swollen Neck Glands ❑
Chemotherapy ❑	Jaw Pain ❑	Thyroid Problems ❑
Circulatory Problems ❑	Kidney Disease ❑	Tonsillitis ❑
Congenital Heart Lesions ❑	Liver Disease ❑	Tuberculosis ❑
Cortisone Treatments ❑	Low Blood Pressure ❑	Tumor or growth on head/neck ❑
Cough-persistent or bloody ❑	Mitral Valve Prolapse ❑	Ulcer ❑
Diabetes ❑	Nervous Problems ❑	Venereal Disease ❑

To the best of my knowledge, all of the answers are true and correct. If I ever have any change in my health, or, if my medications change, I will inform Dr. Fugier immediately.

_____ Date _____ Signature of patient, Parent or Guardian

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