

Dental History

Date of Last Dental Visit: _____ Reason for this visit: _____

- Does dental treatment make you nervous? No Slightly Moderately Extremely

Do you presently or have ever had any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Jaw pops or clicks |
| <input type="checkbox"/> Pain in or around ear | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Difficulty opening/Closing | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Gum Surgery | <input type="checkbox"/> Previous Periodontal Treatment |
| <input type="checkbox"/> Bad dental experience | <input type="checkbox"/> Had immediate relative lose all their natural teeth |

- Are your teeth sensitive to : Hot Cold Biting Sweets

- Are you happy with the appearance of your teeth? Yes No

Patient Health Information

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

- How would describe your present health? Excellent Good Fair Poor

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

- Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

- Are you taking any medications (This includes over the counter drugs)? Yes No

If yes, please explain: _____

- **Are you allergic to any medications?** Yes No If yes, what: _____

- Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

- How would you describe your sleep? Does snoring have a significant effect on the quality of your life?

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian _____

