



Shalimar
FAMILY DENTISTRY
The "red carpet" experience in dental care.

Dental History		Yes	No	Health History		Yes	No
Are your teeth sensitive to:				Are you under a physicians care at this time?			
	Heat?			Name of your MD:			
	Cold?			Contact Information:			
	Sweets?						
	Pressure?						
Does food catch between your teeth?				Have you ever been treated for a bone disorder such as osteoporosis?			
Do your gums bleed when brushing or flossing?				Have you ever been treated for any kind of cancer?			
Do you feel you have bad breath?				Have you ever received radiation and/or chemotherapy?			
Have you ever had a "deep cleaning"?				Do you have or have you ever had any of the following?:			
Do you have any problems with your jaw joint (TMJ)?				Heart murmur/Mitral Valve Prolapse?			
	Clicking?			Respiratory Conditions including asthma?			
	Jaw Pain (Joints, ear side of face)?			Rheumatic Fever?			
	Difficulty chewing?			Epilepsy?			
	Locking open or closed?			High Blood Pressure?			
	Headaches when awakening?			Low Blood Pressure?			
Have you ever had an adverse reaction to anesthetics?				Artificial Joints?			
If yes, please describe:				Pacemaker?			
Do you currently or have you ever used tobacco products?				Heart Disease ?			
When was your last oral cancer screening?				Heart Attack?			
Do you have any lumps, bumps or sores in your mouth that have not healed withint 10 days?				Hepatitis (Please circle) A B C			
Do you have missing teeth?				HIV/AIDS?			
How long have they been missing?			Years	Prolonged Bleeding?			
Rate your smile on a scale of 1-10				Healing Complications?			
What would make you smile a 10?				Drug Allergies: Please list			
Why did you leave your last dentist?				Are you diabetic? If yes, Type I or Type II			
When was your last dental appointment?			Months	Is your diabetes well controlled?			
When was you last dental cleaning?			Months	Do you have a sugar source with you at all times?			
Have you ever have orthodontic treatment?				Did you know there is a direct link between diabetes and gum disease?			
Rate your anxiety you have about dental treatment 1-10				Women:			
Are you interested in learning more about sedation options for dental care?				Are you pregnant?			
What is your chief dental concern?				Are you nursing?			
				Are you taking birth control pills?			
Please <u>list</u> all medications you are taking including over the counter medications:		What can we do to make your appointment more comfortable?					

By signing below you acknowledge you have provided an accurate health history to your dental office. Please keep your dental team informed of any changes in your health as changes can affect your oral health. Additionally, many diseases first symptoms present in the oral cavity and you may be asked to see your medical doctor for diagnosis.

Signature of Patient or Legal Guardian of Patient _____ Date _____

Patient Printed Name _____ Printed Name of Guardian _____

Provider Reviewed and Date _____