Dental History

Address Dentist's Email	What would you like us to do	today?.		į,	Are you in dental dis	scomfo	rt today?
Date of last dental care	Former Dentist	,	Addres	s			
Date of last dental care Check (/) yes							
Check (/) yes							
Y Bad breath							
Sensitivity to cold Sensitivity when biting Sensitivity to cold Sensitivity when biting Sensitivity to hot Sores or growths in mouth How often do you brush? How do you feel about the appearance of your teeth? Floss? How do you feel about the appearance of your teeth? Floss? F	Check (V) yes if your	ave Ha	a problems with any of the ic	<i>,</i>			
□Y Closing or popping law □Y Loose teeth or broken fillings □Y Sensitivity to hot □Y Sores or growths in mouth How often do you brush? How often do you brush? Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? □Y □N Cher information about your dental health or previous treatment.	☐Y Bad breath						•
How do you feel about the appearance of your teeth? Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?							-
How do you feel about the appearance of your feeth? Are you over experienced an adverse reaction during or in conjunction with a medical or dental procedure? Physician's name	Y Clicking or popping jaw	ΩY	Loose teeth or broken fillings	U Y	Sensitivity to hot		
Check (/) YES F YOU HAVE HAD ANY OF THE FOLLOWING: Y Anaphylaxis	How often do you brush?		on of your tooth?		F1055 :		
### Cither information about your dental health or previous treatment #### MEDICAL HISTORY Physician's name							
### Physician's name							
Phone Date of last visit	Other information about your	dental i					7:
Phone Date of last visit			MEDICAI		STORY		
Date of last visit							
Are you ourently under physician care? Y N If yes, describe Have you ever taken Fen-Pherv/Redux? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y N Taking birth control pills? Y N Nursing? Y Nursi							
Are you currently under physician care?	Date of last visit		Have you had any	seriou	is illnesses or operations?	ΩY	□N
Have you ever had a blood transfusion?	If yes, describe					-	
Have you ever taken Fen-Phen/Redux?	Are you currently under physic	cian ca	re? DY DN If yes, de	scribe .		_	
Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N Check (/) YES F YOU HAVE HAD ANY OF THE FOLLOWING: Y AIDS/HIV Positive Y Cough, persistent Y Jaw pain Y Shingles Y Anaphylaxis Y Cough up blood Y Kidney disease or Y Shortness of breath Y Anaphylaxis Y Epilepsy Y Liver disease Y Spina Biffda Y Arthritis, Rheumatism Y Epilepsy Y Liver disease Y Spina Biffda Y Arthritis, Rheumatism Y Epilepsy Y Liver disease Y Spina Biffda Y Arthritis, Rheumatism Y Epilepsy Y Liver disease Y Spina Biffda Y Arthritis, Rheumatism Y Epilepsy Y Liver disease Y Spina Biffda Y Arthritis, Rheumatism Y Epilepsy Y Liver disease Y Spina Biffda Y Arthritis, Rheumatism Y Epilepsy Y Liver disease Y Spina Biffda Y Arthritis, Rheumatism Y Epilepsy Y Liver disease Y Spina Biffda Y Arthritis, Rheumatism Y Epilepsy Y Material allergies (latex, wool, metal, chemicals) Y Stroke (latex, wool, metal, chemicals) Y Surgical implant Y Asthram Y Equation Y Stroke (latex, wool, metal, chemicals) Y Swelling of feet Y Swelling of feet Y Arthritis Y Surgical implant Y Swelling of feet Y Revous problems Y Repartisery Y Tobacco habit Y Tosillitis Y P Sychilatric care Y Thyroid disease or malfunction Y Report prior Y Report prior Y Tobacco habit Y Tosillitis Y P Revous problems Y Repartisery Y Tobacco habit Y Tosillitis Y Report prior Y Report prior Y Report prior Y Tobacco habit Y Tosillitis Y Report prior Y Report prior Y Tobacco habit Y Tosillitis Y Report prior Y Y Tobacco habit Y Report prior Y Re	Have you ever had a blood tra	ansfusio	on? DY DIN If yes, giv	e appro	oximate dates	_	
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Check (/) YES F YOU HAVE HAD ANY OF THE FOLLOWING: Y AlDS/HIV Positive				Taki	ng birth control pills?	Y ON	
Y AlDS/HIV Positive	,		•		g co p		
Anaphylaxis Y Cough up blood Y Kidney disease or Y Shortness of breath Y Anemia Y Diabetes Y Epilepsy Y Liver disease Y Spina Biffida Y Artificial heart valves Y Fainting Y Artificial joints Y Food allergies (latex, wool, metal, chemicals) Y Astrima Y Glaucoma Y Headaches Y Moreous problems Y Heart murmur Y Chemical dependency Y Heart murmur Y Chemical dependency Y Heart murmur Y Chemical dependency Y Heart murmur Y Pacemaker/ Y Rajid weight gain or loss Y Tobsicco habit Y Cortisone treatments Y Hepatitis Y High blood pressure Y Rheumatic/Scarlet fever Y V V V V V V V V V V V V V V V V V V			· · · · · · · · · · · · · · · · · · ·		laura e la	O.V.	Chinalas
Y Anemia					•		•
Y Arthritis, Rheumatism Y Epilepsy Y Liver disease Y Spina Bifida Y Arthritis, Rheumatism Y Epilepsy Y Extroke (latex, wool, metal, chemicals) Y Surgical implant chemicals) Y Asthma Y Glaucoma Y Mitral valve prolapse Y Swelling of feet or ankles Y Revous problems Y Swelling of feet or ankles Y Revous problems Y Thyroid disease or maifunction Y Pacemaker/ Heart surgery Y Tobacco habit Y Pacemaker/ Heart surgery Y Pacemaker/ Heart surgery Y Pacemaker/	• •		• '	UY			
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Y Artificial joints							•
Attrictal joints			•		(latex, wool, metal,		
Atopic (allergy prone) Y			•				•
Y Back problems Y Heart murmur Y Pacemaker/ Pacemaker/ Thyroid disease or malfunction Y Blood disease Y Heart problems Y Pacemaker/ Heart surgery Y Tobacco habit Tobacco				ΠY	·	ш т	
Y Blood disease Y Heart problems Heart surgery Y Tobacco habit					•	ΠY	
Y Cancer				ūΥ			•
Y Chemical dependency						ΠY	Tobacco habit
Abnormal bleeding Y Radiation treatment Y Tuberculosis Ulcer/Colitis Ulcer/Colitis V Herpes Y Respiratory disease Y V V V V V V V V V				٠.	-	ΩY	Tonsillitis
Y Circulatory problems Y Herpes Y Hepatitis Y Respiratory disease Y Venereal disease Y Venereal disease Y Venereal disease Y Respiratory disease Y Venereal disease Y		-				ΠY	Tuberculosis
AUTHORIZATION hepatitis		ΠÝ	Herpes			ΠY	Ulcer/Colitis
AUTIONIZATION I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will informate dentist. authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for service rendered. I authorize the use of this signature on all insurance submissions. authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financial esponsible for all charges whether or not paid by insurance. Date Date		ΠY	Hepatitis			ΠY	Venereal disease
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