IT IS IMPORTANT THAT WE KNOW ABOUT YOUR MEDICAL AND DENTAL HISTORY. THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH. THIS INFORMATION IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE. THANK YOU FOR TAKING THE TIME TO COMPLETELY FILL OUT THIS QUESTIONNAIRE.

DENTAL HISTORY

PLEASE CHECK ONE

Do you have a SPECIFIC DENTAL PROBLEM? Describe: _____

HOW LONG SINCE You have seen a Dentist? _____

Last COMPLETE dental exam, date: _____

Last FULL MOUTH X-RAYS, DATE (18 small films or panoramic): _____

Are you UNHAPPY with the APPEARANCE of your teeth? _____ ☐ Yes ☐ No

Do you dislike the COLOR, SIZE, or SHAPE of your teeth? Describe: _____ ☐ Yes ☐ No

_____

If your smile was IMPROVED, would you feel more CONFIDENT? _____ ☐ Yes ☐ No

How would you like your smile to look BETTER or DIFFERENT? Describe: _____

_____

Are you troubled by BAD TASTES in your mouth or BAD BREATH? _____ ☐ Yes ☐ No

Have you had any PERIODONTAL (GUM) treatment? _____ ☐ Yes ☐ No

Do your gums BLEED, or feel TENDER or IRRITATED? _____ ☐ Yes ☐ No

Do you want to keep your remaining teeth? _____ ☐ Yes ☐ No

How do you feel about getting and maintaining a healthy mouth? Describe: _____

Would you like to know more about PERMANENT REPLACEMENTS? _____ ☐ Yes ☐ No

Are your teeth SENSITIVE to hot, cold, sweets, pressure? _____ ☐ Yes ☐ No

Are you aware of GRINDING, CLENCHING, your teeth? _____ ☐ Yes ☐ No

Do you have HEADACHES, EARACHES, or NECK PAIN? _____ ☐ Yes ☐ No

Have you worn BRACES on your teeth? (ORTHODONTICS) _____ ☐ Yes ☐ No

Do you BRUSH and FLOSS on a routine basis? Describe _____ ☐ Yes ☐ No

Name of previous Dentist: _____

MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS? _____ ☐ Yes ☐ No

Are you under a PHYSICIAN'S CARE now? _____ ☐ Yes ☐ No

What MEDICATIONS are you presently taking? _____

For What? _____

Are you PREGNANT? _____ ☐ Yes ☐ No Weeks _____

Do you SMOKE? _____ ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

- ☐ Heart Disease or Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Hemophilia (bleeding problems)
- ☐ Bruise Easily
- ☐ Heart Murmur
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Congenital Heart Lesions
- ☐ Mitral Valve Prolapse
- ☐ Chemotherapy (Cancer, Leukemia)
- ☐ Drug Abuse
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Artifical Joints (hip, knee)
- ☐ Rheumatic Fever
- ☐ Radiation Treatment
- ☐ Glaucoma
- ☐ Kidney Trouble
- ☐ Cortisone Medicine
- ☐ Drug Addiction
- ☐ Ulcers
- ☐ Fever Blisters
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Nervousness
- ☐ Anemia
- ☐ Stroke
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Pain in Jaw Joints
- ☐ Cosmetic Surgery
- ☐ Sinus Trouble
- ☐ AIDS or HIV Positive
- ☐ Epilepsy or Seizures
- ☐ Veneral Disease
- ☐ Syphilis, Gonorrhea, etc.
- ☐ Emphysema
- ☐ Psychiatric Treatment
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Hay Fever
- ☐ Alcoholism
- ☐ Fainting or dizzy spells

Are you allergic to or have you reacted adversely to any of the following medications?
☐ Aspirin ☐ Nitrous Oxide ☐ Dental Anesthetics ☐ Codeine ☐ Erythromycin ☐ Penicillin ☐ Latex gloves

Are you aware of being allergic to any other medications or substances? If yes, please list: _____

Is there any other medical or dental information that you feel we should know about? _____

Family Physician Name _____ Phone No. _____ Date of last visit _____

X _____ Date _____

PATIENT Signature (Parent of Child)

Reviewed by: DOCTOR _____ Date _____ B.P. _____