



<b>DENTAL HISTORY</b>	<b>CHART #</b>
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HOW LONG Since you have seen a dentist? _____	Last COMPLETE Dental Exam DATE: _____
REASON for this Visit _____	Last FULL MOUTH X-RAYS DATE: _____

What do you LIKE or DISLIKE about your previous dental experience? \_\_\_\_\_

GENERAL	YES	NO	PERIODONTAL DISEASE	YES	NO
Is your present dental health POOR?			Is painless . . . and often victims are unaware they have the disease. It affects 3 out of 4 in the USA.		
Do you wear DENTURES? (Partials or Full)?			Are your gums red, swollen, or tender?		
Are you APPREHENSIVE about Dental Treatment			Are your gums pulling away from your teeth?		
Have you had any PERIODONTAL (gum) treatments?			Do you see pus between your teeth and when your gums are pressed?		
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle those that apply)			Do your gums bleed when you brush your teeth or toothpick between them?		
Are you aware of grinding or clenching your teeth?			Are your permanent teeth loose or separating?		
Do you have HEADACHES, EARACHES, or NECK PAINS?			Is there any change in the way your teeth fit together when you bite?		
Have you worn BRACES on your teeth? (ORTHODONTICS)?			Is there any change in the fit of your partial dentures?		
Do you REGULARLY use DENTAL FLOSS?			Do you have bad breath and bad taste?		

How do you FEEL about your teeth? \_\_\_\_\_

Are you PLEASSED with the APPEARANCE of your teeth? \_\_\_\_\_

What would you LIKE TO CHANGE about your teeth? \_\_\_\_\_

Please rank the following in order in which they would KEEP YOU FROM having dental treatment.

# FEAR OF PAIN	# COST OF TREATMENT	# LACK OF CONCERN	# MISSING WORK TIME
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**MEDICAL HISTORY**

Do you require pre-medication before dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had any complications following dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently taking any medication or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever taken Phen fen? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been admitted to a hospital during past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there any other Medical or Dental information that you feel I should know about? _____	Explain: _____ Explain: _____ List: _____ Explain: _____ Explain: _____ Name of Physician: _____ Phone: _____
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Have you ever had any of the following? Please check those that apply:

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

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I certify that there have been no changes in my health except as noted below. Signature \_\_\_\_\_ Date \_\_\_\_\_

Date	Change	Signature	Date	Change	Signature