Medical and Dental

DENTAL HISTORY

Reason for today's visit: Exam Emergency Consultation
Are you in pain? No Yes How Long?_____
Please indicate any of the following problems with a check mark:
Discomfort, clicking, or popping in jaw Lost/Broken fillings Stained Teeth Red, swollen, or bleeding gums.

Teeth grinding Locking jaw Sensitive tooth, teeth, or gums Ringing in ears Bad breath

Blisters/Sores in or around mouth Broken/Chipped tooth

Other:_____
Do you require antibiotics prior to cleanings? Yes No Don't know
Do you consider yourself to be a nervous patient? Yes No
Previous Dentist:_____ (_____)_____
Name Phone#
Last Dental exam:_____/_____/_____ Last Dental X-rays:_____/_____/_____
Times a day you brush?_____ Times a week you floss?_____
Do you use an electric toothbrush? Yes No Do you use a soft bristle toothbrush? Yes No
How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

MEDICAL HISTORY

What medications are you taking? **Nerve pills** **Pain killers (including aspirin, etc.)** **Muscle relaxers**
Stimulants **Blood thinners** **Tranquilizers** **Insulin** **Meds for Osteoporosis**
Other (s), please list:_____
Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/ Stroke	**Y N** Thyroid Problems	**Y N** Cancer/ Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./ Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/ Ulcers	**Y N** Artificial Bones/ Joints	**Y N** Diabetes/ Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/ Seizures/ Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/ Drug Abuse	**Y N** Severe/ Frequent Headaches	**Y N** High/ Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had:_____
_____
Are you allergic to any of the following? Latex Penicillin/ Amoxicillin Tetracycline Aspirin
Dental Anesthetics Codeine Foods:_____ Others:_____
Do you use tobacco? No Yes/How used?_____ How Much?_____ How Long?_____
Please rate your general health from 1 - 10:_____ Do you wear contact lenses? Yes No
Have you ever taken the drug Phen-fen or Redux? Yes No
For Women: Are you taking Birth Control pills? Yes No
Are you pregnant? No Yes/How long?_____ Are you nursing? Yes No

Signature_____ Date_____/_____/_____
By signing above, I acknowledge that the above is true and correct to the best of my knowledge.