

Dental History

Reason for today's visit: _____	Chewing on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist: _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State: _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit: _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays: _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Mark on "yes" or "no" to indicate if you have had any of the following:</i>	Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Lips or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you own a Nightguard? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

Health History

Physician's Name: _____ Date of last visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These combinations of Ionimin Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Mark "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Medications for above? _____
Arthritis, Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthetic Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No
What? _____	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
When? _____	G.U.R.D. <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
or Blood Thinners <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes (Oral) <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth <input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
C.O.P.D. <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No

Women: Are you pregnant? Yes No Due date _____ Are you nursing? Yes No
 Taking birth control pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis: _____

Pharmacy Name: _____

Phone: () _____

Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthesia
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> _____
<input type="checkbox"/> Latex	<input type="checkbox"/> _____

Update #1 (Please make updates accordingly)

Has there been any changes in your health since your last dental appointments? Yes No

Are you taking any new medications? Yes No

New Address? Yes No

New Phone #'s? Yes No

New Insurance? Yes No

Signature _____ Date _____

Update #2 (Please make updates accordingly)

Has there been any changes in your health since your last dental appointments? Yes No

Are you taking any new medications? Yes No

New Address? Yes No

New Phone #'s? Yes No

New Insurance? Yes No

Signature _____ Date _____