

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Address \_\_\_\_\_

Check (✓) if you have or have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad Breath                        | <input type="checkbox"/> Grinding Teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding Gums                     | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw           | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL 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 include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you ever had any serious illnesses or operations?? ☐ Yes ☐ No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had problems with any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Congenital Heart lesions | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism         | <input type="checkbox"/> Cortisone Treatments     | <input type="checkbox"/> Hernia Repair         | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves       | <input type="checkbox"/> Cough, Persistent        | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Cough up Blood           | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems                 | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Bleeding Abnormally           | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Blood Disease                 | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemical Dependency           | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemotherapy                  | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Circulatory Problems          | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Rheumatic fever       |   |

List medications you are currently taking:

_____	_____
_____	_____
_____	_____

Allergies:

- |  |   |                                 |                                      |
|--|---|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin       | <input type="checkbox"/> Latex  | _____                                |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            | <input type="checkbox"/> None   |                                      |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

\_\_\_\_\_  
Signature of of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

***Payment is due in full at time of treatment unless prior arrangements have been approved.***