

Dental Health History

Please check any questions that you would answer "YES"

- | | |
|---|---|
| <input type="checkbox"/> Are you apprehensive about dental treatment? | How often do you brush? _____ |
| <input type="checkbox"/> Do you wear dentures? | How often do you floss? _____ |
| <input type="checkbox"/> Does food catch between your teeth? | <input type="checkbox"/> Do you grind or clench your teeth? |
| <input type="checkbox"/> Are your teeth sensitive when chewing? | <input type="checkbox"/> Do you have earaches or pain in front of the ears? |
| <input type="checkbox"/> Are your teeth sensitive to cold? | <input type="checkbox"/> Do you have a temporomandibular disorder (TMJ)? |
| <input type="checkbox"/> Are your teeth sensitive to hot? | <input type="checkbox"/> Are you unable to open your mouth wide? |
| <input type="checkbox"/> Are your teeth sensitive to sweet? | <input type="checkbox"/> Have you had a trauma to the jaw? |
| <input type="checkbox"/> Do your gums bleed easily? | <input type="checkbox"/> Are you a habitual gum-chewer? |
| <input type="checkbox"/> Do your gums feel swollen or tender? | <input type="checkbox"/> Do you take fluoride supplements? |
| <input type="checkbox"/> Have you ever been treated for gum disease? | <input type="checkbox"/> Are you unhappy with the appearance of your teeth? |

Medical Health History

Heart Problems

- Chest pain
- High blood pressure
- Low blood pressure
- Heart murmur
- Heart valve problem
- Rheumatic fever
- Artificial heart valve
- Pacemaker

Blood Problems

- Easy bruising
- Frequent nose bleeding
- Abnormal bleeding
- Blood disease-anemia
- Ever had blood transfusion?

M.D. Required PREMEDICATION Reason:

Endocrine

- Diabetes
- Family history of diabetes
- Thyroid problems

Nervous system

- Stroke
- Headaches
- Seizures/Epilepsy
- Psychiatric Treatment

Bone/joint problems

- Arthritis
- Back or neck pain
- Joint replacement

Respiratory

- Tuberculosis
- Emphysema
- Asthma
- Sinus problem
- Difficulty breathing while lying down
- Hay fever

Other

- Hepatitis: Type _____
- Ulcer
- Kidney or bladder problem
- Venereal disease
- History of alcohol or drug abuse
- Do you smoke/use tobacco in any form?

Allergies Are you allergic or have you ever had an adverse reaction to any of the following?

- Local anesthetics-Novocain
- Penicillin
- Sulfa Drugs
- Other antibiotics~please specify:

- Aspirin, acetaminophen, or ibuprofen
- Codeine, Demerol, or other narcotics
- Reaction to metal
- Latex
- Other allergies~please specify:

If yes, how much? _____

- Radiation therapy
- Chemotherapy
- Tumors/growth
- Cancer
- HIV+
- AIDS

Women

- Taking contraceptives
- PREGNANT: delivery date _____
- Nursing

Please list all medications you are currently taking: _____

SIGNATURE:

DATE: