DAURITY

FAMILY DENTISTRY

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions to the best of your ability.

Primary Care Physician: _____Phone: (___) ____-_____

Y N Abnormal Bleeding	Y N Difficulty Breathing	Y N Low Blood Pressure
Y N Allergies	Y N Drug Abuse	Y N Mitral Valve Prolapse
Y N Anemia	Y N Fainting Spells	Y N Pace Maker
Y N Angina Pectoris	Y N Fever Blisters/Cold Sores	Y N Pre-Med
Y N Arthritis	Y N Frequent Headaches	Y N Psychiatric Problems
Y N Artificial Bones/Joints	Y N HIV+/AIDS	Y N Reflux
Y N Artificial Heart Valve	Y N Heart Attack	Y N Seizures/Epilepsy
Y N Asthma	Y N Heart Murmur	Y N Sickle Cell Disease
Y N Blood Thinner	Y N Heart Surgery	Y N Sinus Problems
Y N Cancer-Chemotherapy	Y N Hemophilia	Y N Sleep Apnea
Y N Cancer-Radiation	Y N Hepatitis A	Y N Stroke
Y N Cancer-Remission	Y N Hepatitis B	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N Hepatitis C	Y N Tuberculosis
Y N Dementia/Alzheimer's	Y N High Blood Pressure	Y N Ulcers
Y N Diabetes	Y N Kidney Problems	Y N Venereal Disease/STD
Y N Dialysis	Y N Liver Disease	Y N Smoke/Tobacco Use

Allergies:

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Sulfa
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline
Other: _____

Females Only:

Y N Are you taking birth control pills?
Y N Are you nursing?
Y N Are you pregnant? # of weeks_____

Please list all medications that you are currently taking:_____
_____
_____

Any other medical conditions not listed please describe: _____
_____
_____

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Dental History

Why are you seeking dental care at this time? _____
You feel your dental health is: Good/Fair/Poor
Approximate date of your last checkup/cleaning? _____
Why did you leave your previous dentist? _____
Is there anything we can do to better accommodate you during your visit? _____
Have you been told by your physician that you require antibiotics before dental treatment? Yes/No

Y N Is it important for you to keep your teeth?
Y N Are you satisfied with the appearance of your teeth?
Y N Are you satisfied with the function of your teeth?
Y N Does food frequently get caught between your teeth?
Y N Do your gums often bleed while brushing?
Y N Have you noticed loosening of your teeth?
Y N Have you ever injured your teeth, head, neck or jaw?
Y N Do you have difficulty eating or swallowing?
Y N Do you have dry mouth?
Y N Have you had a change in your ability to taste foods?
Y N Are your teeth sensitive to hot or cold?
Y N Do you experience bad breath?

Problems of the jaw-Have you noticed:

Y N Clicking of the jaw?
Y N Pain (joint, ear, side of face)?
Y N Difficulty opening or closing?
Y N Difficulty chewing?

Oral Habits: Do you?

Y N Clench or grind your teeth?
Y N Bite your lips or cheeks frequently?

Have you had:

Y N Orthodontic treatment? (Braces)
Y N Oral Surgery?
Y N Gum treatment?
Y N A bite guard/nightguard or other appliance?
Y N Oral cancer?

Do you currently have:

Y N Dental pain?
Y N Sores or swelling in your mouth?
Y N A partial/full denture?
Y N Dental implants?

Do you have any dental anxiety? Yes/No
Have you had any difficulty with dental treatment in the past? Yes/No
Please explain: _____
_____
_____
How often do you brush your teeth? _____
How often do you floss? _____