DENTAL HISTORY

Chief dental concern: ____________________

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Are you nervous about having dental treatment? ☐ Yes ☐ No
Have you ever had a bad dental experience? ☐ Yes ☐ No
Do you have difficulty or pain when opening (yawning)? ☐ Yes ☐ No
Does your jaw get stuck, locked or "go out"? ☐ Yes ☐ No
Difficulty / pain when chewing, talking, or using your jaws? Teeth? ☐ Yes ☐ No
Do you have noises in your jaw joints? ☐ Yes ☐ No
Pain about the ears, temples or cheeks? ☐ Yes ☐ No
Does your bite feel uncomfortable or unusual? ☐ Yes ☐ No
Have you had a recent injury to your head / jaw? ☐ Yes ☐ No

Have you been treated for a jaw joint problem? ☐ Yes ☐ No
Do your teeth ever feel loose? ☐ Yes ☐ No
Does food catch in-between your teeth? ☐ Yes ☐ No
How often do you brush?______ Floss?______ ☐ Yes ☐ No
Any difficulty chewing your food? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ Yes ☐ No
Are your teeth sensitive to cold / heat / etc? ☐ Yes ☐ No
Have you ever been premedicated for dental work? ☐ Yes ☐ No
Do you have frequent Headaches? ☐ Yes ☐ No
Are you happy with the way your smile looks? ☐ Yes ☐ No
If not, what would you change? ____________________

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HEALTH HISTORY

Are you having any pain or discomfort at this time? ☐ Yes ☐ No
Do you smoke or use tobacco in any form? ☐ Yes ☐ No
Have you been hospitalized in the past 2 years? ☐ Yes ☐ No
Have you been under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No
Physician Name ____________________
Address ____________________ Phone:____________

Are you currently taking any medications / drugs? ☐ Yes ☐ No
If yes, please list: ____________________
List Medications: ____________________

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Women: Are you pregnant? ☐ Yes ☐ No
Please list any serious medical condition(s) that you have/had:

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Please check any of the following which you have now or have had in the past?

- ☐ Angina Pectoris
- ☐ Heart Disease / Attack / Stroke
- ☐ Heart Failure
- ☐ High / Low Blood Pressure
- ☐ Congenital Heart Defect
- ☐ Heart Murmur / Rheumatic Fever
- ☐ Heart Surgery
- ☐ Heart Pacemaker
- ☐ Artificial Heart Valve
- ☐ Diabetes
- ☐ Blood Transfusion / Anemia
- ☐ Sickle Cell Disease
- ☐ Bruise Easily
- ☐ Hemophilia
- ☐ Liver Disease / Yellow Jaundice
- ☐ Kidney Failure/Disfunction
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Glaucoma
- ☐ Chemotherapy / Cancer
- ☐ X-ray / Cobalt Treatment
- ☐ Cosmetic Surgery
- ☐ Emphysema / Asthma
- ☐ Cough / Tuberculosis (TB)
- ☐ Arthritis / Rheumatism
- ☐ Cortisone Medicine
- ☐ Venereal Disease
- ☐ A.I.D.S. / H.I.V.
- ☐ Hepatitis: A B C **(circle one)**
- ☐ Frequent Headaches
- ☐ Pain in Jaw Joint
- ☐ Artificial Joints (Hip, Knee)
- ☐ Scarlet Fever
- ☐ Fever Blisters / Cold Sores
- ☐ Fainting / Dizzy Spells
- ☐ Epilepsy / Seizures
- ☐ Hay Fever / Sinus Trouble
- ☐ Allergies / Hives
- ☐ Shingles
- ☐ Nervousness
- ☐ Psychiatric Treatment
- ☐ Drug / Alcohol Addiction

Are you allergic or have you reacted adversely to the following?

Please Circle

- Aspirin
- Darvon
- Codeine
- Demerol
- Percodan
- Valium
- Scopolamine
- Sleeping Pills (Nembutal / Seconal)
- Penicillin
- Erythromycin
- Tetracycline
- Other Antibiotics
- Latex
- Metals / Jewelry
- Nitrous Oxide
- Local Anesthetic (Novocaine / Xylocaine)

Are you aware of being allergic to any other medications or substances? If yes, please list:

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also give permission to the doctor and his staff to use any photos taken for lecturing and continuing education purposes.

Signature ____________________ Date ____________________

Form AD HH 04/25/08