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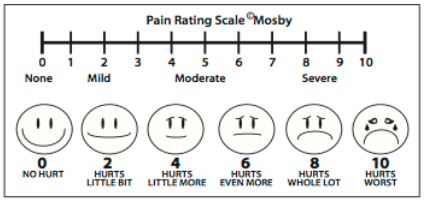
DENTAL AND MEDICAL HISTORY

NAME: _____ **DOB:** _____

1) THE MAIN REASON FOR MY DENTAL APPOINTMENT IS: _____

2) ARE YOU IN DENTAL PAIN? YES NO
IF YES, ON THE PAIN SCHEDULE BELOW PLEASE CIRCLE HOW MUCH PAIN YOU ARE IN:



WHERE IS THE PAIN?

UPPER RIGHT	UPPER FRONT	UPPER LEFT
LOWER RIGHT	LOWER FRONT	LOWER LEFT

DESCRIBE THE PAIN: THROBBING, SHARP, CONSISTENT, INTERMITTENT, DULL

3) DATE OF LAST DENTAL EXAMINATION (MM/YY) _____

4) HOW SATISFIED HAVE YOU BEEN WITH YOUR PREVIOUS DENTAL CARE?

1	2	3	4	5
NOT SATISFIED				*VERY SATISFIED*

5) DO YOU FEAR RECEIVING DENTAL CARE? YES NO UNSURE

THE FOLLOWING INFORMATION IS ESSENTIAL FOR THE SAFE AND EFFECTIVE DIAGNOSIS AND TREATMENT OF EACH PATIENT.
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

6) CONGENITAL HEART DISEASE/ HEART MURMUR/RHEUMATIC FEVER	Y	N
7) HEART ATTACK	Y	N
8) IRREGULAR HEART BEAT	Y	N
9) ANGINA/CHEST PAIN	Y	N
10) HEART SURGERY	Y	N
11) ARTIFICIAL HEART VALVE	Y	N
12) HEART PACE MAKER	Y	N
13) HIGH BLOOD PRESSURE	Y	N
14) LOW BLOOD PRESSURE	Y	N
15) STROKE/PARALYSIS	Y	N
RESPIRATORY		
16) ASTHMA	Y	N
17) BREATHING PROBLEM (SLEEP APNEA, EMPHYSEMA, SHORTNESS OF BREATH, OXYGEN DEPENDENT, COUGH)	Y	N
18) TUBERCULOSIS	Y	N
GASTRO-INTESTINAL		
19) KIDNEY DISEASE	Y	N
20) LIVER DISEASE/YELLOW JAUNDICE	Y	N
21) STOMACH/INTESTINAL DISEASE/ULCERS REFLUX	Y	N
NEUROLOGY		
22) CONVULSIONS/SEIZURES/EPILEPSY	Y	N
23) NUMBNESS OR TINGLING/BACKPAIN	Y	N
24) PSYCHIATRIC TREATMENT	Y	N
25) FAINTING/DIZZINESS	Y	N

ENDOCRINE		
26) DIABETES TYPE 1 TYPE 2	Y	N
27) STEROID TREATMENT (CORTISONE)	Y	N
HEMATOLOGY		
28) BLEEDING/BRUISING EASILY/ BLOOD DISORDER	Y	N
29) IMMUNE SYSTEM (LUPUS, IMMUNODEFICIENCY, SJOGRENS)	Y	N
INFECTIOUS DISEASE		
30) HIV/AIDS	Y	N
31) HERPES	Y	N
32) HEPATITIS A, B or C	Y	N
MUSCULOSKELETAL		
33) RHEUMATISM/ARTHRITIS/PAIN IN JOINTS	Y	N
34) ARTIFICIAL JOINT	Y	N
35) OSTEOPOROSIS/BISPHOSPHONATE THERAPY *(Boniva, Fosamax, Zometa, etc.)*	Y	N
GENERAL		
36) CURRENT CANCER	Y	N
37) PAST CANCER	Y	N
38) RADIATION THERAPY	Y	N
39) CHEMOTHERAPY	Y	N
40) RECENT WEIGHT GAIN/LOSS	Y	N
41) FENh PHEN USE	Y	N
42) DRUG/ALCOHOL TREATMENT	Y	N
43) HIVES/RASH	Y	N
44) DIFFICULTY HEARING	Y	N
45) EYE PROBLEMS (DRY EYES/GLAUCOMA)	Y	N
46) WOMEN ONLY: ARE YOU OR COULD YOU BE PREGNANT?	Y	N

47) ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE? _____

_____

48) HAVE YOU BEEN HOSPITALIZED IN THE PAST YEAR? IF YES - WHAT WERE YOU TREATED FOR? _____

_____

_____

_____

49) HAVE YOU EXPERIENCED AN UNUSUAL OR ALLERGIC REACTION TO ANY OF THE FOLLOWING?

_____ LOCAL ANESTHETIC
_____ PENICILLIN
_____ SULFA DRUGS
_____ ASPIRIN
_____ CODEINE
_____ NARCOTICS
_____ LATEX RUBBER
_____ METALS
_____ OTHERS _____

50) PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING:
(INCLUDING OVER THE COUNTER, OR SUPPLEMENTS OR HERBALS)

NAME	DOSAGE	ROUTE OF INTAKE	MEDICAL CONDITION

51) TOBACCO USE
CIGARETTES
_____ QUIT: DATE _____
_____ NEVER
_____ CURRENT SMOKER: PACKS/DAY_____ NUMBER OF YRS _____

OTHER TOBACCO: PIPE _____ CIGAR _____ SNUFF _____ CHEW _____ BETEL QUID_____

ARE YOU INTERESTED IN QUITTING? NO_____ YES_____

52) ALCOHOL USE
DO YOU DRINK ALCOHOL? _____ YES _____ NO NUMBER DRINKS/WEEK_____

53) DRUG USE
DO YOU USE ANY RECREATIONAL DRUGS? _____ YES _____ NO
HAVE YOU EVER USED NEEDLES? _____ YES _____ NO

54) DO YOU FEEL SAFE AT HOME? _____ YES _____ NO

55) DO YOU HAVE ACCESS TO MEDICAL CARE?
NAME OF FACILTY:_____
DOCTORS NAME: _____ PHONE:_____

56) HAVE YOU HAD A SCREENING FOR THE FOLLOWING?
COLON CANCER (IF ABOVE 50 YR OF AGE) . . . . . .Y N
BREAST CANCER (IF ABOVE 40 YR OF AGE) . . . . . .Y N
BLOOD PRESSURE. . . . . .Y N
CHOLESTEROL/LIPIDS (IF ABOVE 35 YR OF AGE) . . . . . .Y N
IMMUNIZATIONS (FLU SHOTS, PNEUMONIA). . . . . .Y N

57) WEIGHT_____ HEIGHT_____

I CERTIFY THAT ALL THE INFORMATION I HAVE PROVIDED IS TRUE TO MY KNOWLEDGE.

PATIENT'S SIGNATURE_____ DATE_____