LAST DENTAL VISIT_____**PREVIOUS DENTIST**_____**TODAY'S DATE**_____

Do you have any specific concerns today?

Do you have any concerns regarding past dental treatment?

Are you nervous about seeing the dentist?_____

How often do you brush?_____
How often do you floss?_____

(please circle)
Y N I like my smile
Y N I want my teeth whiter
Y N I prefer tooth colored fillings
Y N My gums bleed while brushing
Y N My gums feel tender or swollen
Y N I have problems eating
Y N I have had a facial or jaw injury
Y N I have had orthodontics
Y N I clench or grind my teeth during the day or sleeping

I consider my health to be __Excellent ___Good ___Fair ___Poor

Do you or have you had any of the following? Please circle Y for Yes and N for No

Y N Heart Disease
Y N Heart Murmur/Valve Prolapse
Y N Pacemaker/Heart Valve
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Abnormal Blood Pressure
Y N Anemia
Y N Prolonged Bleeding Disorder
Y N Tuberculosis or Lung Disease
Y N Asthma
Y N Hay Fever
Y N Sinus Trouble
Y N Epilepsy/Seizures
Y N Ulcers
Y N Liver Disease
Y N Jaundice
Y N Hepatitis Type____
Y N Diabetes
Y N Dry Mouth
Y N Infectious Mononucleosis (Mono)
Y N Herpes
Y N Arthritis
Y N Kidney Disease
Y N Tumor or Malignancy
Y N Cancer/Chemotherapy
Y N Radiation Treatment
Y N Drug/Alcohol Dependency
Y N AIDS
Y N Immune Suppressed Disorder
Y N Hearing Loss
Y N Thyroid
Y N Sleep Apnea – If so do you use C-Pap Y N
Y N History of emotional or nervous disorders
Y N Any unlisted health concerns?
If so, what

Y N Artificial joints __Hips ___Knee ___other

Y N I usually take antibiotic prior to dental treatment

Y N I smoke or use tobacco.
--------If yes, how much per day?___How many years?____

Y N GERD Gastro-esophageal reflux disease

Are you allergic to any of the following?
Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Penicillin
Y N Codeine
Y N Latex, Metals, Plastic
Y N Local Anesthetics (Novocaine)
Y N Other Medications_____
Y N Other foods or things_____

WOMEN:
Y N Are you taking birth control medication?
Y N Are you or could you be pregnant or nursing?

PHYSICIAN NAME:_____

LIST MEDICATIONS/AND OR SUPPLEMENTS:

_____
_____
_____
_____
_____
_____
_____

Patient Name:_____**Date of Birth**_____