

Patients Dental Health

Why have you come in to see us today?

Previous Dentist

Last Visit

Date of last cleaning

Reasons for changing dentists:

What problems have you had with past dental treatment?

Are you nervous about seeing a dentist? Yes! No If yes, please tell us why:

(please circle Y for Yes, N for No)

Y N I clench or grind my teeth during the day or while sleeping.

Y N My gums feel tender or swollen

Y N My gums bleed while brushing or flossing.

Y N I have problems eating.

Y N I like my smile.

Y N I have had orthodontics.

Y N I would like to be sedated for dental treatment

Y N I have had a facial or jaw injury.

Y N I avoid brushing part of my mouth due to pain.

Y N I want my teeth straight.

Y N I want my teeth whiter.

Patients Medical History

Y N Heart Disease	Y N Liver Disease	Y N Heart Murmur/Mitral Valve Prolapse	Y N Jaundice
Y N Stroke	Y N Hepatitis Type	Y N Congenital Heart Lesions	Y N Diabetes
Y N Rheumatic Fever	Y N Abnormal BP	Y N Infectious Mononucleosis /Mono	Y N Anemia
Y N Herpes	Y N Prolonged Bleed	Y N Arthritis	Y N HIV
Y N Tuberculosis	Y N Asthma	Y N Kidney Disease	Y N Tumor or Malignancy
Y N Fainting Spells	Y N Sinus Trouble	Y N Cancer/Chemotherapy	Y N Glaucoma
Y N Epilepsy/Seizures	Y N Radiation Treatment	Y N Ulcers	Y N History of Drug Addiction
Y N Emotional/Nervous Disorders	Y N Implants/Artificial Joints: <input type="checkbox"/>Hip <input type="checkbox"/>Knee <input type="checkbox"/>Other		Y N I smoke or use tobacco.
Y N Are you taking birth control? Y N Are you or could you be pregnant or nursing?			
Y N I usually take an antibiotic prior to dental treatment.			
Y N I have had major surgery: Year Type of operation, please list all			

Do you have any allergies, please list all.

Please list all of the Medications you are Currently Taking.

Medication	Condition
Medication	Condition
Medication	Condition
Medication	Condition