Dental Health History

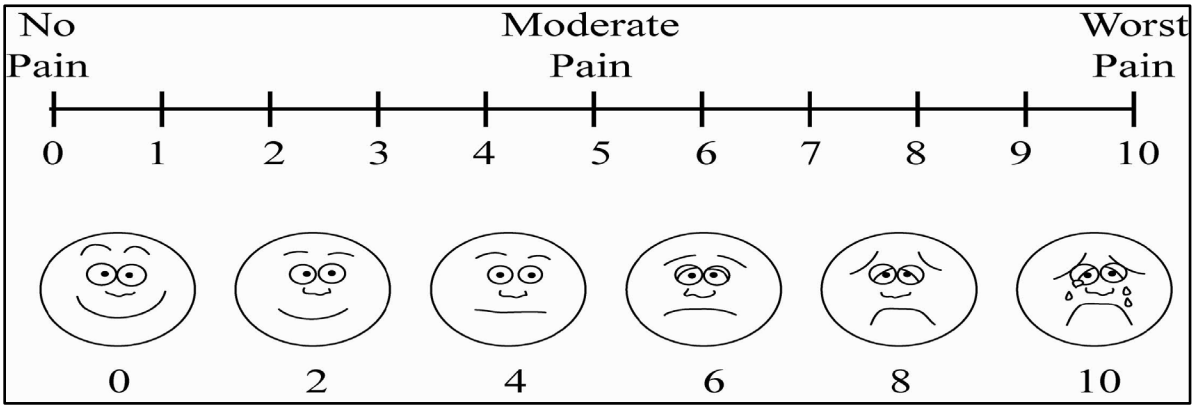
Patient Name:_____Date of Birth:_____

What is the reason for your visit today: **_____**

Are you experiencing any dental pain?

If yes, please provide details (where in your mouth, for how long, etc.) _____

_____



Do you have any allergic reactions to medications or latex? Please circle all that apply and list any others.	*Latex* *Penicillin or other antibiotics* *Nickel* *Acrylic* *Metal* *Aspirin* *Codeine* *Iodine* *Local anesthetics such as Lidocaine* *Other:*

FOR STAFF USE ONLY

Blood Pressure _____ Pulse _____

Temperature _____

Weight _____

SpO2 (pulse oximeter) _____

Dental Health History

Please answer all of the following questions by circling YES or NO.

Abuse as Adult (victim)	Yes	No		COPD	Yes	No		Liver Disease	Yes	No
Abuse as Child (victim)	Yes	No		Depression	Yes	No		Meningitis	Yes	No
ADD/ADHD	Yes	No		Diabetes mellitus	Yes	No		Mental Health Disorder	Yes	No
Alcoholism	Yes	No		Drug Addiction	Yes	No		MRSA History of Infection	Yes	No
Allergies	Yes	No		Emphysema/COPD	Yes	No		Myocardial infarction	Yes	No
Anemia	Yes	No		Glaucoma	Yes	No		Nerve / muscle disease	Yes	No
Anxiety	Yes	No		Heart Disease	Yes	No		Osteoporosis	Yes	No
Arthritis / Joint disorder	Yes	No		Heart Failure	Yes	No		Pacemaker (or Defibrillator)	Yes	No
Asthma	Yes	No		Heart Murmur	Yes	No		Seizures / Epilepsy	Yes	No
Autism	Yes	No		Heart Endocarditis	Yes	No		Sickle Cell Anemia	Yes	No
Bisphosphonate Therapy	Yes	No		History of Blood Transfusions	Yes	No		STD	Yes	No
Broken Jaw	Yes	No		HIV/AIDS	Yes	No		Stomach Ulcers	Yes	No
Cancer	Yes	No		Hyperlipidemia	Yes	No		Stroke	Yes	No
Cataracts	Yes	No		Hypertension	Yes	No		TB Disease	Yes	No
Clotting Disorder	Yes	No		Kidney Disease	Yes	No		Thyroid Disease	Yes	No
Congenital Heart Defect	Yes	No								
Active Heart Murmur	Yes	No		Pregnant	Yes	No		Surgical Prosthesis	Yes	No
Blood Disorders	Yes	No		If Yes, Due date				Heart Surgery	Yes	No
Hepatitis (A, B, C or other)	Yes	No		Are you under the care of a Doctor?	Yes	No		Tumors	Yes	No
Artificial Joints (Hip / Knee /Ankle / Shoulder / Other	Yes	No		If yes, what is their name?				Have you taken Fosamax, Actonel, or Boniva?	Yes	No
Artificial Heart Valve (Heart Valve Replacement)	Yes	No		Breathing or Respiratory Problems	Yes	No		Angina (Chest Pain)	Yes	No
Cold Sores	Yes	No		Oral Herpes	Yes	No		Neurological Disorders	Yes	No
History of Paresthesia	Yes	No		Sinus Problems	Yes	No		Shunts	Yes	No
Heart Defects	Yes	No		Kidney Stones	Yes	No		Scarlet Fever	Yes	No
Appendectomy	Yes	No		Cosmetic surgery	Yes	No		Small intestine surgery	Yes	No

TERRY REILLY

Dental Health History

Brain surgery	Yes	No		Eye surgery	Yes	No		Spine surgery	Yes	No
Breast surgery	Yes	No		Fracture surgery	Yes	No		Third molar extraction	Yes	No
CABG	Yes	No		Hernia repair	Yes	No		Tonsillectomy	Yes	No
Cholecystectomy	Yes	No		Joint replacement	Yes	No		Valve replacement	Yes	No
Colon surgery	Yes	No		Prostate surgery	Yes	No		Vasectomy	Yes	No

Do you have any disease, conditions, problems or surgeries not listed here? Please list.	

Do you smoke? If yes; how much per day? For how long?	Yes	No
Do you use smokeless tobacco? If yes; how much per day? For how long?	Yes	No
Alcohol use? If yes; how much per day? For how long?	Yes	No
Drug use? If yes; what drugs?_____ For how long?	Yes	No

Do you have regular dental checkups?	Date of last exam:	
Do you have difficulty opening your mouth?	Yes	No
Do you have difficulty chewing?	Yes	No
Does your jaw click, pop, or lock open?	Yes	No
Do you have any history of sores or growths in your mouth?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you have dry mouth?	Yes	No
Are your teeth sensitive to hot or cold?	Yes	No
Do your gums bleed when you brush or floss your teeth?	Yes	No
Does dental treatment make you nervous?	Yes	No
Have you had any serious injury with your face or mouth?	Yes	No
Have you had any trouble with previous dental treatment or dental anesthetic?	If yes, please explain:	

Dental Health History

What pharmacy do you use?	

Are you currently taking any prescription medication, over the counter items or herbal supplements? If so, please list:

Name	Dosage	Reason for taking

Please answer the following questions for all children

Does your child receive fluoride from any of the following sources	Supplement - Fluoridated Water - Toothpaste Fluoride Rinse - None	
Do they suck their thumb, finger?	Yes	No
Does a parent or adult help them brush?	Yes	No
Do they eat sugary foods and/or snacks? ***If yes, what and how much?***	Yes	No
Do they drink anything besides water or milk? ***If yes, what and how much?***	Yes	No

Is or was the child given a bottle or Sippy-cup to suck on to fall asleep?	Yes No

In the last 2 weeks, have you felt Depressed or sad mood, most of the day, nearly every day?	Not at All **0**	Several days **1**	More than Half days **2**	Nearly every day **3**
In the last 2 weeks, have you felt diminished interest/pleasure in activities most of the day?	Not at All **0**	Several days **1**	More than Half days **2**	Nearly every day **3**