TERRY REILLY

Dental Health History

Patient Name:____Date of Birth:___________________________

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

Are you experiencing dental pain?	Yes (see below)	No

Please rate your pain intensity today between 1 – 10

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

0 2 4 6 8 10

Is it possible that you are pregnant?	Yes	No
Are you allergic to latex?	Yes	No
Are you allergic to nickel, acrylic or other?	Yes	No
Have you ever had any bleeding that required treatment?	Yes	No
Are you under the care of a medical doctor?	Yes	No
Have you been hospitalized in the last 5 years?	Yes	No
Current or Past Osteoporosis Therapy or other Bisphosphonates?	Yes	No
Have you taken the following medications: Fosamax, Actonel, Boniva?	Yes	No
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

Updated Date:___________________________

Dental Health History

Drug use? If yes; what drugs? ______ For how long?	Yes	No
In the last 2 weeks, have you felt Depressed or sad mood, most of the day, nearly every day?	Not At All Several days 0 1	More than Half days Nearly every day 2 3
In the last 2 weeks, have you felt diminished interest/ pleasure in activities most of the day?	Not At All Several days 0 1	More than Half days Nearly every day 2 3

Patient Name:______________________Date of Birth:______________

Please answer all of the following questions by circling YES or NO.
Do you have or have you ever had any of the following?

Active Heart Murmur	Yes	No
Alcohol or Substance Abuse	Yes	No
Anemia (Bleeding Problem / Other blood disease)	Yes	No
Angina (Chest Pain)	Yes	No
Arrhythmias (Irregular Heart Beat)	Yes	No
Arthritis (Osteo or Rheumatoid)	Yes	No
Artificial Heart Valve (Heart Valve Replacement)	Yes	No
Artificial Joints (Hip / Knee /Ankle / Shoulder / Other	Yes	No
Asthma	Yes	No
Blood Aids or HIV Virus	Yes	No
Blood Disorders	Yes	No
Blood Transfusions	Yes	No
Breathing or Respiratory Problems	Yes	No
Cancer	Yes	No
Cold Sores	Yes	No

Updated Date:______________

Dental Health History

Condition		
Coronary Heart Disease	Yes	No
Diabetes	Yes	No
Heart Attack	Yes	No
Heart Defects	Yes	No
Heart Surgery	Yes	No
Hemophilia	Yes	No
Hepatitis (A,B,C or other)	Yes	No
High Blood Pressure	Yes	No
History of Paresthesia	Yes	No
Kidney Disease	Yes	No
Kidney Stones	Yes	No
Liver Disease	Yes	No
Mitral Valve Prolapse	Yes	No
Neurological Disorders	Yes	No
Oral Herpes	Yes	No
Pacemaker (or Defibrillator)	Yes	No
Scarlet Fever	Yes	No
Seizures / Epilepsy	Yes	No
Shunts	Yes	No
Sickle Cell Anemia	Yes	No
Sinus Problems	Yes	No
Stroke	Yes	No
Surgical Prosthesis	Yes	No
Thyroid	Yes	No
Tumors	Yes	No

Patient Name:____Date of Birth:__________________________

Updated Date:__________________________

Dental Health History

<table>
<tr><td>Do you have any disease, conditions or problems not listed here?

Please list.</td><td></td><td rowspan="4"><u>For Office Use Only:</u></td></tr>
<tr><td>Please list any hospitalizations and surgeries</td><td></td></tr>
<tr><td>Do you have any allergic reactions to medications or latex? Please circle all that apply.</td><td rowspan="2">Latex Penicillin or other antibiotics

Aspirin Codeine Metal Iodine

Local anesthetics such as Lidocaine

Other:</td></tr>
<tr><td>What pharmacy do you use?</td></tr>
</table>

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

Updated Date:__________________________

Dental Health History

Patient Name:____Date of Birth:__________________________

Do you have regular dental checkups?	Date of last exam:
Have you had any trouble with previous dental treatment?	If yes, please explain:
Have you noticed any lumps or sores in your mouth?	Yes No
Do your gums bleed when you brush your teeth?	Yes No
Do you clench or grind your teeth?	Yes No
Do you have any pain in the mouth, face, eyes, neck or throat?	Yes No
Have you had injuries to your face, jaw or teeth?	Yes No
Are you unhappy with the look of your teeth and/or smile?	Yes No
How many times a day do your brush?	
How many times a day do you floss?	

Please answer the following questions for all children

Do they suck their thumb or finger?	Yes No
Do they use fluoride toothpaste?	Yes No
Do they use any other fluoride products, like mouthwash or prescription fluoride?	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

Please answer the following for children ages 0 - 5 years

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

Updated Date:__________________________

Dental Health History

Updated Date:___________________________