DENTAL AND MEDICAL HISTORY FORM

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

ENDOCRINE
26) DIABETES TYPE 1 TYPE 2 ............................................ Y N
27) STEROID TREATMENT (CORTISONE) ................................ Y N

HEMATOLOGY
28) BLEEDING/BRUISING EASILY/ ..................................... Y N
   BLOOD DISORDER
29) IMMUNE SYSTEM ..................................................... Y N
   (LUPUS, IMMUNODEFICIENCY, SJOGRENS)

INFECTION 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 . Y N
   (Boniva, Fosamax, Zometa, etc.)

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: ......................................................... Y N
   ARE YOU OR COULD YOU BE PREGNANT?
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    ______ CODEINE
   ______ PENICILLIN         ______ NARCOTICS
   ______ SULFA DRUGS        ______ LATEX RUBBER
   ______ ASPIRIN           ______ METALS
   ______ OTHERS
   _______________________________________________________________________________________

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

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<th>DOSAGE</th>
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<th>MEDICAL CONDITION</th>
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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 FACILITY: ___________________________________________________________________________
   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_________________________