NAME ______________ ______________ __ AGE ___ SEX: M ☐ F ☐ Patient #____________

Last First MI Social Security #

DENTAL HISTORY

Referring Dentist ____________ ____________ City ________________

First Name Last Name

Briefly describe your problem: ________________________________

How long have you had this problem? _____Day(s) _____Weeks(s) _____Months(s) _____ Years(s)

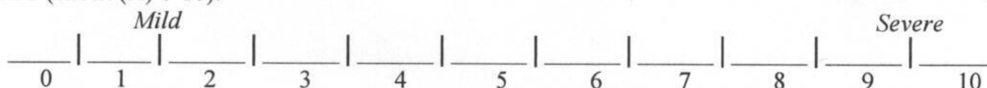
Check (X) all that apply:

PAIN: ☐ Never (If checked, go to SWELLING) **LOCATION:** ☐ Upper Left ☐ Upper Right ☐ Upper Front

☐ In the Past ☐ Today ☐ Lower Left ☐ Lower Right ☐ Lower Front

DURATION: ☐ Seconds ☐ Minutes ☐ Hours ☐ Constant **QUALITY:** ☐ Dull pain ☐ Throbbing pain ☐ Sharp Pain

PAIN SCALE (check (X) 0-10):



PROVOKED BY: ☐ Cold ☐ Hot ☐ Biting ☐ Sweet ☐ Spontaneous (unprovoked) ☐ Other ______________

SWELLING: ☐ None ☐ In the Past ☐ Today **Today's Anxiety Level:** (0-10)_____

HEALTH HISTORY

Physician's Name____________ ____________ City____________ Date of last visit______________

First Name Last Name

Have you ever taken any of the group of drugs referred to as "fen-phen?" ☐Yes ☐ No

Have you ever taken any of the group of drugs referred to as "bisphosphonates?" ☐Yes ☐ No (fosamax, actonel, aredia, zometa)

Have you been hospitalized or had a serious illness within the past 5 years? ☐Yes ☐ No

Do you require premedication with antibiotics for any of the following reasons?

☐ Artificial Joints ☐ Heart ☐ Rheumatic Fever ☐ Phen/Fen

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? CHECK (YES) OR (NO)

Y/ N		Y/ N		Y/ N	
☐ ☐	AIDS/HIV	☐ ☐	Congenital Heart Condition	☐ ☐	Psychiatric Care
☐ ☐	Alzheimer's disease	☐ ☐	Diabetes (type__________)	☐ ☐	Radiation Treatment
☐ ☐	Anemia (type__________)	☐ ☐	Ear (Cochlear) Implant	☐ ☐	Respiratory / Breathing Problems
☐ ☐	Arthritis, Rheumatism	☐ ☐	Emphysema	☐ ☐	Rheumatic Fever
☐ ☐	Artificial Heart Valve (Year_____)	☐ ☐	Epilepsy or Seizures	☐ ☐	Sinus Trouble
☐ ☐	Artificial Joints (Year_____)	☐ ☐	Glaucoma	☐ ☐	Steroid Treatment
☐ ☐	Asthma	☐ ☐	Heart Murmur	☐ ☐	Stroke
☐ ☐	Back / Neck Problems	☐ ☐	Heart Disease / Heart Surgery	☐ ☐	TMJ Disorder
☐ ☐	Bleeding Abnormality	☐ ☐	Hepatitis (type________)	☐ ☐	Tuberculosis
☐ ☐	Blood Thinners	☐ ☐	High Blood Pressure	☐ ☐	Tumor or Growth
☐ ☐	Cancer	☐ ☐	Kidney Disease	☐ ☐	Ulcer
☐ ☐	Chemical Dependency	☐ ☐	Liver Disease	☐ ☐	Venereal Disease
☐ ☐	Chemotherapy	☐ ☐	Pacemaker	☐ ☐	Other ______________

FEMALES ONLY: Are you Pregnant? ☐ Yes ☐ No Due Date__________

Are you Nursing? ☐ Yes ☐ No

Are you taking Birth Control Pills? ☐ Yes ☐ No

List any **MEDICATIONS** you are currently taking and the correlating diagnosis: ______________________

____

ALLERGIES ☐ Aspirin or NSAIDs ☐ Local Anesthetic ☐ Latex ☐ Penicillin (or other antibioticis)

☐ Codeine ☐ Sulfa Drugs ☐ Iodine ☐ Other ______________

I have answered above completely and accurately.

Signature (patient or parent/guardian) ______________________________ **DATE**______________