

NAME _____ AGE _____ SEX: M F Patient # _____
Last First MI Social Security #

DENTAL HISTORY

Referring Dentist _____ City _____
First Name Last Name

Briefly describe your problem: _____

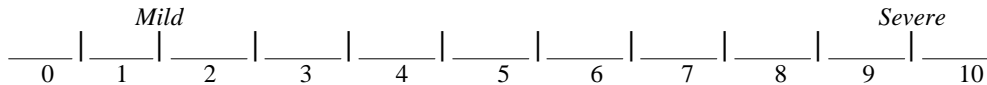
How long have you had this problem? _____ Day(s) _____ Weeks(s) _____ Months(s) _____ Years(s)

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 |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Condition | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> <input type="checkbox"/> Diabetes (type _____) | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> <input type="checkbox"/> Anemia (type _____) | <input type="checkbox"/> <input type="checkbox"/> Ear (Cochlear) Implant | <input type="checkbox"/> <input type="checkbox"/> Respiratory / Breathing Problems |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve (Year _____) | <input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints (Year _____) | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Steroid Treatment |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Back / Neck Problems | <input type="checkbox"/> <input type="checkbox"/> Heart Disease / Heart Surgery | <input type="checkbox"/> <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding Abnormality | <input type="checkbox"/> <input type="checkbox"/> Hepatitis (type _____) | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Tumor or Growth |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> 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 antibiotics)
 Codeine Sulfa Drugs Iodine Other _____

I have answered above completely and accurately.

Signature (patient or parent/guardian) _____ **DATE** _____

