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):

Mild *Severe*

0	1	2	3	4	5	6	7	8	9	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**_____