

Part II- Patient Dental History

Do you have a dental cleaning and exam every six months? _____ Date of last exam _____

Do you have, or have you had, any of the following: (Please circle.)

Family members who have had orthodontics	yes	no
Missing, extracted, or extra teeth	yes	no
Trouble chewing	yes	no
Teeth that are sensitive to heat or cold	yes	no
Bleeding gums or a bad taste in the mouth	yes	no
Root canals, crowns, or bridges	yes	no
Habits like thumb/finger sucking, grinding, or clenching	yes	no
Clicking, popping, or pain in the jaw (TMJ)	yes	no
Injuries to the face, jaw, mouth or teeth	yes	no

Please explain: _____

Part III - Patient Medical History

Are you in good health? _____

Have you been treated by a physician for any condition in the last two years? _____

Do you now have any, or have you ever had any of the following? (Please circle.)

AIDS	yes	no
Anemia, blood/bleeding problems	yes	no
Asthma or breathing difficulties	yes	no
Circulation/blood pressure problems	yes	no
Endocrine problems	yes	no
Headaches or earaches	yes	no
Hepatitis	yes	no
Stomach, liver, or kidney problems	yes	no
Tuberculosis	yes	no
Allergies	yes	no
Arthritis, bone/muscle problems	yes	no
Birth defects	yes	no
Diabetes	yes	no
Fainting/dizziness	yes	no
Heart disease	yes	no
Seizure disorder	yes	no
Tonsil and adenoid problems	yes	no
Tumors, cysts, or cancer	yes	no

If yes, please explain: _____

Please list any medications taken: _____

Are you allergic to or have you ever had a reaction to any medication or drug? _____

Are you allergic to or have you ever had a reaction to latex? _____

Do you need to be pre-medicated with an antibiotic before an invasive dental procedure? _____

Do you regularly take Advil, Aleve, aspirin or other anti-inflammatory products? _____

Do you drink carbonated beverages (soda) on a daily basis? _____ If so, how much? _____

Are you a regular user of tobacco products such as cigarettes or smokeless tobacco, etc.? _____

Female patients: To the best of your knowledge, are you pregnant? _____

Please provide any additional information you feel may be helpful in the diagnosis and treatment of your condition: _____