

WOODDELL & PASSARO

Restorative Dentistry

DENTAL HISTORY

1. What is your reason for this visit? _____
2. Please describe any dental problem that is bothering you at this time:

3. When was your last visit to the dentist? _____ Reason for last visit _____
4. Have you ever had or do you now have: (Please check all that apply)
 Problems with dental treatment Food catching between teeth Sensitivity to sweets, biting
 Problems with anesthetics Loose teeth Sensitivity to hot/cold
 Pain in teeth or jaws Bleeding gums Sensitivity to jewelry or metal
 Clenching or grinding of teeth Periodontal Disease Other: _____
 Clicking or pain in jaw joint Dry mouth
 Headaches Snoring problem
 Injuries to your teeth or jaw Orthodontics
5. Do you have missing teeth? If so, how have they been replaced? _____
6. Do you gag easily? _____
7. How often do you brush your teeth? _____ Floss them? _____
8. What type of toothpaste do you use? _____ Mouthwash? _____
9. How do you feel about the appearance of your smile? _____
10. Have you ever had a bad experience in a dental office? If yes, please explain:

11. Please add anything you feel is important for us to know about your health or dental history:

Signature of patient or guardian: _____ Date: _____

FOR OFFICE USE

Notes:

MEDICAL INFORMATION

The answers you provide to the following questions will help us determine the proper treatment for you.
These records are kept confidential in our office.

Patient Name: _____

Birth Date: _____ **Age:** _____

YES **NO**

YES **NO**

Do you have or have you ever had any of the following medical conditions:

____ Are you in good health?
 ____ Have there been any changes in your general health within the last year?
 ____ Are you now under the care of a Physician? If so, what for:

Rheumatic fever or rheumatic heart disease
 Heart murmur
 High or low blood pressure
 Chest pains
 Previous heart attack
 Shortness of breath after mild exercise
 Ankle swelling

Name of Medical Doctor: _____

Pacemaker or artificial valves

____ Have you had any serious illnesses, injuries or operations? Please list:

Bypass surgery
 Asthma or hay fever
 Hives or a skin rash
 Fainting spells or seizures
 Diabetic or blood sugar problems
 Hepatitis, jaundice or liver disease

____ Have you ever stayed overnight in a hospital?

Arthritis
 Stomach ulcers
 Kidney disease

____ Have you had excessive bleeding from an extraction or previous surgery?

Tuberculosis
 Venereal disease

____ Do you bruise easily?

Cancer
 Glaucoma

____ Have you ever required a blood transfusion?

Frequent headaches
 Stroke

____ Is there any reason to believe that your immune system may be compromised?

Scarlet fever
 Anemia

____ Do you have any blood disorders?

Tumor or abnormal growth
 Bleeding or clotting problems

____ Are you currently taking any medications or drugs? Please list:

Liver problems
 Sinus problems
 Lung problems

____ Do you have any organ transplants?

Persistent cough
 Seasonal allergies
 Thyroid problems

____ Have you ever had any radiation treatments or chemotherapy?

Epilepsy
 Leukemia

____ Have you had any serious trouble associated with previous dental treatment? If so, what?

Fibromyalgia
 Prosthesis or artificial joint
 HIV/AIDS

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Please explain:

____ Have you ever used Phen-Fen, even once?

Are you allergic to or ever had a bad reaction to:

____ Women: Are you pregnant?

Dental anesthetics

____ Do you smoke? If so, how many packs per day: _____

Antibiotics

____ Do you use smokeless tobacco?

Latex

____ Does your jaw pop, click, or grind when you open?

Medications: _____

____ Do you have any body piercings or tattoos?

Are you on any other treatment or taking medications that could affect your dental treatment? (herbs, vitamins, etc.) Please list:
