Patient's Dental Health

TOPSAIL DENTAL

Why have you come in to see us today (e.g., pain, checkup, etc.)_____

Previous dentist:_____ Last visit:_____ Last cleaning date:_____

Reasons for changing dentists:_____

What problems have you had with past dental treatment:_____

Are you nervous about seeing a dentist: ❑ Yes ❑ No If yes, please tell us why:_____

How often do you brush:_____ Do you floss: ❑ Yes ❑ No How often:_____

❑Y ❑N I clench/grind my teeth during the day or while sleeping
❑Y ❑N My gums bleed while brushing or flossing
❑Y ❑N I like my smile
❑Y ❑N I prefer tooth-colored fillings
❑Y ❑N I avoid brushing part of my mouth due to pain
❑Y ❑N My gums feel tender or swollen

❑Y ❑N I have problems eating
❑Y ❑N I have had orthodontics
❑Y ❑N I have had a facial or jaw injury
❑Y ❑N I want my teeth straight
❑Y ❑N I want my teeth whiterq1

What are your dental priorities (e.g., dental health, financial considerations, apprentice, etc.):_____

Patient's Medical History

I consider my health to be: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have any of the following:

❑Y ❑N Heart Disease
❑Y ❑N Heart Murmur/Mitral Valve Prolapse
❑Y ❑N Stroke
❑Y ❑N Congenital Heart Lesions
❑Y ❑N Rheumatic Fever
❑Y ❑N Abnormal Blood Pressure
❑Y ❑N Anemia
❑Y ❑N Prolonged Bleeding Disorder
❑Y ❑N Tuberculosis or Lung Disease
❑Y ❑N Asthma
❑Y ❑N Hay Fever
❑Y ❑N sinus Trouble
❑Y ❑N Epilepsy/Seizures
❑Y ❑N Ulcers
❑Y ❑N Implants/Artificial Joints: ❑Hip ❑Knee ❑Other
❑Y ❑N Liver Disease
❑Y ❑N Jaundice
❑Y ❑N Hepatitis Type ____
❑Y ❑N Diabetes
❑Y ❑N Excessive Urination/Thirst
❑Y ❑N Infectious Mononucleosis
❑Y ❑N Herpes
❑Y ❑N Arthritis
❑Y ❑N Sexually Transmitted Disease
❑Y ❑N Kidney Disease
❑Y ❑N Tumor or Malignancy

❑Y ❑N Cancer/Chemotherapy
❑Y ❑N Radiation Treatment
❑Y ❑N History of Drug Addition
❑Y ❑N Ever taken Pen-Phen or Redux
❑Y ❑N AIDS
❑Y ❑N Immune Suppressed Disorder
❑Y ❑N Hearing Loss
❑Y ❑N Fainting Spells
❑Y ❑N Glaucoma
❑Y ❑N History of Emotion/Nervous Disorder
❑Y ❑N Do you have any other medical problem or medical history NOT listed_____
_____
❑Y ❑N I smoke or use tobacco
If yes, how much per day_____
How many years_____
❑Y ❑N I have consumed alcohol within the last 24 hours.
❑Y ❑N I usually take an antibiotic prior to dental treatment
❑Y ❑N I have had major surgery:
Year_____
Type_____
Year_____
Type_____
Year_____
Type_____

Are you allergic to any of the following?

❑Y ❑N Aspirin
❑Y ❑N Ibuprofen
❑Y ❑N Sulfa Drugs/Sulfites/Sulfides
❑Y ❑N Penicillin
❑Y ❑N Codeine
❑Y ❑N Latex, Metals, Plastics
❑Y ❑N Local Anesthetics (Novocaine)
❑Y ❑N Other Medications_____

Women:

❑Y ❑N Are you taking birth control
❑Y ❑N Are you pregnant or nursing

List all medication you are currently taking:

Medicine	Condition

Physician Name:_____
Address _____
Phone_____ Fax_____

In the event of an emergency, please contact:

Name_____ Relationship_____ Phone_____
Name_____ Relationship_____ Phone_____

Initial medical/dental health reviewed by:

_____ _____ _____ _____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental review by:

_____ _____ _____ _____
Doctor's Signature Date Patient's Signature Date

Doctor Notes:_____
_____
_____
_____