

DENTAL HISTORY

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|---|-------|--------------|---|------------------------------|--------------|
| 1. Reason for visit: | | | | | |
| 2. How often do you brush your teeth? | _____ | Floss? _____ | What texture brush do you use? | Xsoft | Soft |
| 3. Do your gums bleed? | YES | NO | 10. Any head, neck, or jaw injuries? | YES | NO |
| 4. Are your teeth sensitive? | YES | NO | 11. Do you have frequent headaches? | YES | NO |
| 5. Do any teeth feel loose? | YES | NO | 12. Do you clench or grind your teeth? | YES | NO |
| 6. Have you noticed any sores in your mouth? | YES | NO | 13. Do you bite your lips or cheeks frequently? | YES | NO |
| 7. Do you have areas of frequent food impaction? | YES | NO | 14. Do you like the appearance of your teeth? | YES | NO |
| 8. Have you ever had an upsetting dental visit? | YES | NO | 15. Please select if you have had any of the following: | | |
| 9. Please select if you have any of the following jaw problems: | | | Orthodontics (Braces) | Oral Surgery (tooth removal) | |
| Clicking | Pain | Opening | Closing | Chewing | Bite Splints |

MEDICAL HISTORY

PHYSICIAN _____ **DATE OF LAST EXAM** _____ **REASON** _____

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| <p>1. Are you under medical treatment now? YES NO</p> <p>2. Have you been hospitalized for any surgical operation or serious illness? YES NO</p> <p>3. Are you taking any medications including non-prescription medicine? YES NO
if yes, please list all medications below:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>4. Do you smoke tobacco or use spit tobacco (chew)? YES NO</p> <p>5. Alcohol Use (select one): None Rare Social Frequent Daily</p> <p>6. Do you use cocaine or other controlled substances? YES NO</p> | <p>7. Do you have any of the following allergies?</p> <p>Penicillin YES NO</p> <p>Sulfa drugs YES NO</p> <p>Codeine YES NO</p> <p>Latex YES NO</p> <p>Metals (costume jewelry, nickel, etc.) YES NO</p> <p>Other Allergies: (Please Describe Below)</p> <p>_____</p> <p>_____</p> <p>8. WOMEN ONLY:</p> <p>a. Do you think you may be pregnant? YES NO</p> <p>b. Are you nursing? YES NO</p> <p>c. Are you taking birth control pills? YES NO</p> <p>d. Estimated date of delivery: _____</p> |
|---|---|

Please select if you have or have had any of the following:

- | | | | |
|-------------------------|-------------------------|-------------------------|------------------------------|
| Alcoholism | Epilepsy | Hives | Respiratory Problems |
| Anemia | Fainting or Dizziness | Kidney Problems | Rheumatic Fever |
| Arthritis | G-6PD deficiency | Liver Disease | Rheumatism |
| Asthma | Glaucoma | Leukemia | Sexually Transmitted Disease |
| Blood Transfusion | Hay Fever | Mitral valve prolapse | Sickle cell disease |
| Bruise or Bleed easily | Heart Disease or Angina | Nervousness | Sinus Problems |
| Cancer or Tumors | Heart Murmur | Pacemaker | Steroid medications |
| Cold Sores (Herpes) | Heart Surgery | Painful Joints | Stroke |
| Congenital Heart Lesion | Hemophilia | Persistent cough | Thyroid Disease |
| Diabetes | Hepatitis-Type: ____ | Prosthetic Heart valves | Tuberculosis or PPD+ |
| Drug Addiction | High Blood Pressure | Prosthetic Joints | Ulcers or Gastric Reflux |
| Emphysema | HIV+ | Radiation therapy | Yellow Jaundice |

Patient's Signature **Date**
 Parent signature if under 18 years of age.

 Dr. Napieralski//Dr. Wisniewski Date _____

DATE	COMMENTS / CHANGES / UPDATES

PATIENT NAME: _____ **BIRTHDATE:** _____