

Center for Dental Health, La Jolla

DENTAL HISTORY

This information is necessary for our files and will be kept CONFIDENTIAL.

Date _____

Patient Name _____

Last

First

Initial

What is the reason for your visit today?

Previous dentist name _____ Address _____ Phone _____

How often do you have a dental examination? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problem, pain or sensitivity now? YES NO

If yes, please describe: _____

Do you feel nervous about having dental treatment? YES NO

If yes, what is your biggest concern? _____

Have you ever had orthodontic treatment? YES NO

Have you ever had oral surgery? YES NO

Have you ever had periodontal (gum) treatment? YES NO

Have you ever had clicking or popping of jaw? YES NO

Have you ever had joint pain? YES NO

Have you ever had difficulty in opening or closing your mouth? YES NO

Have you ever had mouth odor or bad taste? YES NO

Have you ever had dry mouth? YES NO

Have you ever had food getting caught between your teeth? YES NO

Have you ever had an upsetting dental experience? YES NO

Do you clench or grind your teeth while awake or asleep? YES NO

Do you breathe through your mouth? YES NO

Do you have tired jaw, especially in the morning? YES NO

Do you smoke cigarettes or cigars? YES NO

If yes, how many a day? _____

Do you chew tobacco? YES NO

Are you satisfied with your teeth's appearance? YES NO

Would you like to have whiter teeth? YES NO

Is there anything else about dental treatment that you would like us to know? YES NO

If yes, please describe: _____

PLEASE COMPLETE BOTH SIDES

Center for Dental Health, La Jolla

MEDICAL HISTORY

Patient Name _____

Are you in good general health? YES NO

Are you being treated for any illness now? YES NO

If yes, please describe: _____

Your physician's name _____ Address _____ Phone _____

Are you taking medication, drugs or pills now? YES NO

If yes, please describe: _____

Are you taking Phen-fen now? YES NO

Are you aware of having allergic reactions to any medication or substances? YES NO

If yes, please describe: _____

Have you been hospitalized during the past five years? YES NO

If yes, please describe: _____

Indicate which of the following you have had, or have at present

Heart disease, surgery, attack YES NO Swollen ankles YES NO Radiation therapy YES NO

Heart defect YES NO Fainting, dizzy spells YES NO Cancer YES NO

Artificial heart valve YES NO Stroke YES NO Chemotherapy YES NO

Heart murmur YES NO Diet YES NO Tumors YES NO

Congenital heart disease YES NO Kidney trouble YES NO Venereal disease YES NO

Mitral valve prolapse YES NO Ulcers YES NO A.I.D.S. YES NO

Rheumatic fever YES NO Diabetes YES NO H.I.V. positive YES NO

High blood pressure YES NO Thyroid problems YES NO Cold sores, fever blisters YES NO

Chest pain YES NO Glaucoma YES NO Blood transfusion YES NO

Heart pacemaker YES NO Contact lenses YES NO Hemophilia YES NO

Artificial joints YES NO Hay fever YES NO Sickle cell disease YES NO

TB, emphysema YES NO Latex sensitivity YES NO Bruise easily YES NO

Chronic cough YES NO Allergies or hives YES NO Liver disease YES NO

Asthma YES NO Sinus trouble YES NO Yellow jaundice YES NO

Arthritis, rheumatism YES NO Psychiatric, psychological care YES NO Epilepsy, seizures YES NO

Cortisone medication YES NO Hepatitis YES NO

Recreational drugs YES NO If yes, how much? _____

Alcohol YES NO If yes, how much? _____

Have you lost or gained more than 10 pounds in the past year? YES NO

Do you have or have you had any disease, condition or problem not listed? YES NO

If yes, please describe: _____

Women

Are you pregnant? YES NO _____ months Are you nursing? YES NO Are you taking birth control? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge, Should further information be needed, you have permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature of Patient (Parent if Minor) _____ Date _____ Dr. _____

Recall Review

Signature of Patient (Parent if Minor) _____ Date _____ Dr. _____

Signature of Patient (Parent if Minor) _____ Date _____ Dr. _____

Signature of Patient (Parent if Minor) _____ Date _____ Dr. _____