Medical History

Diamond Bar Dental

Patient Name _____

DENTAL HISTORY

Reason for today's visit_____ Date of last Dental visit_____
Last Dental cleaning_____ Date of last Dental X-rays_____

CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU

_ BAD BREATH _GRINDING TEETH _NAIL BITING _ SENSITIVITY TO SWEETS
_BLEEDING GUMS _ JAW POPPING/CLICK _PENCIL BITING _THUMB SUCKING
_DRY MOUTH _MOUTH BREATHING _SENSITIVITY HOT/COLD _TOBACCO USE
HOW OFTEN DO YOU FLOSS_____ HOW OFTEN DO YOU BRUSH_____

CIRCLE YES OR NO

YES/NO Experiencing dental issues today? **YES/NO** Are you experiencing discomfort?
YES/NO Interested in whiter teeth? **YES/NO** Do you have any missing teeth?

HAVE YOU EVER:

YES/NO Been in an accident causing damage to your teeth?
YES/NO Had Orthodontic Treatment?
YES/NO Received periodontal (Gum) treatment?
YES/NO Experienced loose teeth or changes in bite?

Denture/Partial wearing patients

YES/NO Do you wear a denture or partial? **YES/NO** Are your dentures loose?
YES/NO Does your denture cause irritation/soreness? **YES/NO** How old is your denture?

How would you rate your smile on a scale from 1 to 10, with 10 being most satisfied _____
Are you interested in: Orthodontic treatment? **YES/NO** Cosmetic treatment? **YES/NO**
Do you feel nervous about dental treatment? **YES/NO** if so, Explain_____
Is there anything else about having dental treatment that you would like for us to know?

_____

CONFIDENTIAL HEALTH HISTORY

CIRCLE THE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

YES/NO Is your general health good? If no, explain: _____
YES/NO Have you gone to the hospital, emergency room or had a serious illness in the last three years? If yes, explain:
_____
YES/NO Are you being treated by a physician now? If yes, explain: _____
YES/NO Have you had problems with prior dental treatment? If Yes, explain: _____
YES/NO Have you had any recent surgeries? If yes, explain: _____
YES/NO Are you in pain now? If yes, Explain: _____
YES/NO Have you ever been pre-medicated for dental treatment? If yes, explain: _____

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

YES/NO Alcohol **YES/NO** Antibiotics **YES/NO** Aspirin **YES/NO** Bisphosphinate (Fosamax/Actonel)
YES/NO Over the counter medication **YES/NO** Recreational Drugs **YES/NO** Supplements **YES/NO** Tabacco
YES/NO Blood thinners **YES/NO** Have you ever taken Phen Phen? If yes, when? _____
Other medications (Please list): _____

FOR WOMEN ONLY

YES/NO Are you or could you be pregnant? If yes, how far along? _____

YES/NO Are you nursing? **YES/NO** Are you taking birth control?

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

YES/NO Bleeding Gums	**YES/NO** Difficulty swallowing	**YES/NO** Fainting Spells	**YES/NO** Persistent cough **YES/NO** Swollen ankles
YES/NO Blurred vision	**YES/NO** Dizziness	**YES/NO** Fever	**YES/NO** Recent weight loss
YES/NO Bruise easily	**YES/NO** Dry Mouth	**YES/NO** Headaches	**YES/NO** Sinus problem
YES/NO Chest pain	**YES/NO** Excessive thirst	**YES/NO** Joint pain/stiffness	**YES/NO** shortness of breath

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

YES/NO Aids/Hiv	**YES/NO** Diabetes	**YES/NO** High Blood Pressure	**YES/NO** Stroke
YES/NO Anemia	**YES/NO** Eating Disorders	**YES/NO** Kidney Disease	**YES/NO** Stomach Disease
YES/NO Artificial Joints	**YES/NO** Empyhsema/Lung	**YES/NO** Liver Disease	**YES/NO** Thyroid Disease
YES/NO Arthritis Rheumatism	**YES/NO** Eye Diease	**YES/NO** Osteoporosis	**YES/NO** Transplants
YES/NO Asthma	**YES/NO** Harding of Arteries	**YES/NO** Psychiatric Care	**YES/NO** Tuberculosis
YES/NO Cancer	**YES/NO** Heart Attack	**YES/NO** Rheumatic fever	**YES/NO** Tumors
YES/NO Canker/cold sores	**YES/NO** Heart Disease	**YES/NO** Seizures	**YES/NO** Ulcers
YES/NO Chemotherapy	**YES/NO** Hepatitis	**YES/NO** Sexually Transmitted Disease	
YES/NO Cosmetic Surgery	**YES/NO** Herpes	**YES/NO** Skin Disease	

List any major illnesses not listed above_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING:

YES/NO Asprin	**YES/NO** Erythromycin	**YES/NO** Nitrous Oxide	**YES/NO** Tetracycline
YES/NO Codeine	**YES/NO** Latex	**YES/NO** Penicillin	**YES/NO** Valium
YES/NO Darvon	**YES/NO** Local Anesthetics (Lidocaine)	**YES/NO** Percodan	**YES/NO** Vicodin
YES/NO Dermerol	**YES/NO** Metal	**YES/NO** Sulfa	

OTHER_____

Is there any issue of condition that you would like to discuss with the dentist in private? **YES/NO**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Parent's signature _____ Date_____

Physician's Name _____ Physician's Phone Number (___)_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and or medication. I will not hold my dentist or any other member of my dentist's staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent/Guardian) _____ Date_____

Signature of Dentist _____ Date_____