

PATIENT NO.	DATE	PHYSICIAN NAME	PHYSICIAN PHONE #	BIRTHDATE / /
PATIENT NAME (LAST, MIDDLE, FIRST)			DATE OF LAST PHYSICAL: / /	
ACCOUNT TYPE / INSURANCE PLAN		ADDRESS:		

DOES THE PATIENT HAVE, OR HAS THE PATIENT EVER HAD, ANY OF THE FOLLOWING:

HEART PROBLEMS	YES _____	NO _____	ANEMIA	YES _____	NO _____
HEART MURMURS	YES _____	NO _____	ARTHRITIS	YES _____	NO _____
RHEUMATIC FEVER	YES _____	NO _____	ASTHMA	YES _____	NO _____
HIGH BLOOD PRESSURE	YES _____	NO _____	DIABETES	YES _____	NO _____
LOW BLOOD PRESSURE	YES _____	NO _____	ULCERS	YES _____	NO _____
CIRCULATORY PROBLEMS	YES _____	NO _____	KIDNEY DISEASE	YES _____	NO _____
EXCESSIVE BLEEDING	YES _____	NO _____	LIVER DISEASE	YES _____	NO _____
STROKE	YES _____	NO _____	SEIZURES	YES _____	NO _____
A SHUNT	YES _____	NO _____	NERVOUS PROBLEMS	YES _____	NO _____
AN INTERNAL PROSTHESIS	YES _____	NO _____	PSYCHIATRIC CARE	YES _____	NO _____
BLOOD TRANSFUSION	YES _____	NO _____	MALIGNANCIES	YES _____	NO _____
MEASLES	YES _____	NO _____	RADIATION TREATMENTS	YES _____	NO _____
MUMPS	YES _____	NO _____	ALLERGIES TO ANESTHETICS	YES _____	NO _____
SCARLET FEVER	YES _____	NO _____	ALLERGIES TO MEDICATIONS	YES _____	NO _____
TYPHOID FEVER	YES _____	NO _____	ALLERGIES TO ANYTHING	YES _____	NO _____
HEPATITIS	YES _____	NO _____	ARE YOU PREGNANT	YES _____	NO _____
(YELLOW) JAUNDICE	YES _____	NO _____	ANY PHYSICAL HANDICAPS	YES _____	NO _____
TUBERCULOSIS	YES _____	NO _____	RECENT SEVERE WEIGHT LOSS	YES _____	NO _____
SICKLE CELL ANEMIA	YES _____	NO _____	EXTREME FATIGUE	YES _____	NO _____
TONSILLITIS	YES _____	NO _____	NIGHT SWEATS	YES _____	NO _____
SINUS PROBLEMS	YES _____	NO _____			

PLEASE LIST ANY ALLERGIES _____

DO YOU HAVE OR HAVE YOU BEEN IN CONTACT WITH AIDS YES _____ NO _____

HAVE YOU HAD ANY RECENT HOSPITALIZATIONS YES _____ NO _____

IF SO, EXPLAIN _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS YES _____ NO _____

IF SO, EXPLAIN _____

HAVE YOU HAD ANY PROBLEMS WITH PAST DENTAL TREATMENT YES _____ NO _____

IF SO, EXPLAIN _____

IS THERE ANYTHING ELSE IN YOUR MEDICAL OR DENTAL HISTORY THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT YES _____ NO _____

IF SO, EXPLAIN _____

SIGNATURE: _____ RELATIONSHIP _____
(OVER PLEASE) (OVER PLEASE)

FOR OFFICE USE ONLY:

PREMEDICATION? YES _____ NO _____ SPECIFY _____

REVIEWED BY:

SIGNATURE _____ FOR DENTAL HEALTH ASSOCIATES

REVIEW MEDICAL HISTORY: DATE _____, PATIENT (PARENT) _____, FOR DHA _____

REVIEW MEDICAL HISTORY: DATE _____, PATIENT (PARENT) _____, FOR DHA _____

REVIEW MEDICAL HISTORY: DATE _____, PATIENT (PARENT) _____, FOR DHA _____

REVIEW MEDICAL HISTORY: DATE _____, PATIENT (PARENT) _____, FOR DHA _____

REVIEW MEDICAL HISTORY: DATE _____, PATIENT (PARENT) _____, FOR DHA _____

REVIEW MEDICAL HISTORY: DATE _____, PATIENT (PARENT) _____, FOR DHA _____

REVIEW MEDICAL HISTORY: DATE _____, PATIENT (PARENT) _____, FOR DHA _____

1. ARE YOU HAVING ANY DISCOMFORT AT THIS TIME? YES _____ NO _____

IF SO, WHAT IS THE DISCOMFORT? _____

2. ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH (SMILE) YES _____ NO _____

3. ARE YOUR TEETH SENSITIVE TO COLD? YES _____ NO _____

4. ARE YOUR TEETH SENSITIVE TO HOT? YES _____ NO _____

5. ARE YOUR TEETH SENSITIVE TO SWEETS? YES _____ NO _____

6. ARE YOUR TEETH SENSITIVE TO BITING OR CHEWING PRESSURE? YES _____ NO _____

7. DO YOU BRUSH YOUR TEETH EVERY DAY? YES _____ NO _____

WHEN DO YOU BRUSH? _____

HOW DO YOU BRUSH? _____

8. DO YOU USE DENTAL FLOSS? YES _____ NO _____

9. DO YOU USE A BETWEEN THE TEETH STIMULATOR? YES _____ NO _____

10. DO YOU USE A WATER JET TO CLEAN YOUR TEETH?..... YES _____ NO _____

11. DO YOUR GUMS BLEED? YES _____ NO _____

IF SO, WHEN DO THEY BLEED? _____

12. DO YOU EAT BETWEEN MEALS? YES _____ NO _____

13. DO YOU BRUSH YOUR TEETH AFTER SNACKS? YES _____ NO _____

14. DOES FOOD WEDGE BETWEEN YOUR TEETH? YES _____ NO _____

IF SO, WHEN _____

15. DO YOU CLENCH OR GRIND YOUR TEETH? YES _____ NO _____

IF SO, WHEN _____

16. HAVE YOU EVER HAD GUM TREATMENT? YES _____ NO _____

IF SO, WHEN _____

17. AT TIMES, DO YOU FEEL YOU HAVE BAD BREATH? YES _____ NO _____

18. AT TIMES, DO YOU NOTICE A BAD TASTE IN YOUR MOUTH? YES _____ NO _____

19. DO YOU HAVE ANY PAIN IN OR AROUND YOUR EARS? YES _____ NO _____

20. DO YOU HEAR POPPING, CLICKING, OR SNAPPING NOISES WHEN YOU CHEW? YES _____ NO _____

21. ARE YOU AWARE OF ANY SWELLING OR LUMP IN YOUR MOUTH? YES _____ NO _____

22. DO YOU HAVE ANY OF THE FOLLOWING HABITS:

THUMBSUCKING YES _____ NO _____

FINGER SUCKING YES _____ NO _____

CHEEK OR TONGUE CHEWING YES _____ NO _____

CHEWING OF ANY OBJECT (NAILS, PENCILS, LIPS, ETC.) YES _____ NO _____

23. DO YOU HAVE ANY FEAR OF HAVING DENTISTRY DONE? YES _____ NO _____

24. DO YOU WANT TO KEEP THE NATURAL TEETH YOU STILL HAVE? YES _____ NO _____

25. DO YOU WANT TO AVOID FULL DENTURES? YES _____ NO _____

26. HOW LONG HAS IT BEEN SINCE YOU HAVE BEEN TO A DENTIST? _____

27. WHEN WAS THE LAST TIME YOU HAD XRAYS? _____

28. WHAT WAS DONE THEN? _____

29. HOW OFTEN DO YOU USUALLY GO TO THE DENTIST? _____