Felton Dental Center Date:_____

Dental Health History Form

Patient Name:_____ Nickname:_____

Email address:_____ SSN#_____

Mailing Address:_____
Street *City* *Zip Code*

Phone numbers:_____
Home *Cell*

Date of birth:_____ Sex: M _____ F _____ *(check one)*

If you are completing this form for another person, please let us know your name and relationship to patient

Name_____ Relationship_____

What are your goals in coming to our practice today?

_____

What is important to you in a dentist or dental practice?

_____

What has been your experience with the dentist in the past?_____

Name of former dentist_____

If you left your previous dentist, what are the reasons?_____

Have you had problems with prior dental treatment?_____

Are you experiencing any pain now? ___YES ___NO

If YES, please describe:_____

Have you ever been pre-medicated for dental treatment? ___YES ___NO
If yes, why?_____

Are you anxious about having dental treatment? ___YES ___NO
If YES, would you be comfortable sharing why?_____

Have you ever had orthodontic treatment? ___YES ___NO If yes, when?_____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery?
___YES ___NO If yes, when?_____

Have you ever whitened your teeth? ___YES ___NO If yes, what method?_____

Do your gums bleed when you brush or floss? ___YES ___ NO
Is your mouth dry? ___YES ___ NO
Do you have earaches or neck pains? ___YES ___ NO
Do you have any clicking or popping in the jaw? ___ YES ___ NO
Do you have sores or ulcers in your mouth? ___ YES ___ NO
Have you ever had a serious injury to your head or mouth? ___ YES ___ NO

What concerns do you currently have with your oral health and smile? *(check all that apply)*

___ Jaw joint pain
___ Discolored teeth
___ Tooth shape or size
___ Uncomfortable bite
___ Bad breath
___ Loose tooth/teeth
___ Too much gum tissue when I smile
___ Unhappy with appearance of teeth
___ Overbite or underbite
___ Difficulty chewing
___ Missing teeth
___ Spaces between teeth
___ Speech problems
___Tooth sensitivity to hot/cold, other
___Clenching/grinding of teeth
___ Crowded/Crooked teeth
___ Old fillings (gold or silver)
___ Old crowns
___ Food gets caught between teeth
___ Other

****

GENERAL MEDICAL HEALTH INFORMATION

Are you now under the care of a physician? ___YES ___NO IF yes, who?_____

With which medical group?_____ City_____

Has there been any change in your general health within the past year? ___YES ___ NO

IF YES, what condition is being treated?_____

When did you last have a physical exam?_____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? ___YES ___ NO

IF YES, what was the illness or problem?_____

Please list any regularly taken prescription medications, herbal supplements, or over-the-counter medicines:

_____

_____

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ___YES ___ NO

IF YES, please answer the following:

Date of replacement_____ Have you had any complication?_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) For osteoporosis or Paget's disease? ___YES ___NO

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting for Paget's disease, multiple myeloma or metastatic cancer? ___YES ___ NO IF YES, date treatement began:_____

****

Allergies – Are you allergic to or have you had a reaction to any of the following:

	YES	NO		YES	NO
Local Anesthetics	___	___	Metals	___	___
Aspirin	___	___	Latex (rubber)	___	___
Penicillin /other antibiotics	___	___	Iodine	___	___
Barbiturates, sedatives, sleeping pills	___	___	Animals	___	___
Sulfa drugs	___	___	Food	___	___
Codeine or other narcotics	___	___	Do you have hay fever? (seasonal allergies)	___	___

Do you use controlled substances (drugs) ___ ___

Do you use tobacco? (smoking, snuff, chew, bidis) ___ ___

Please mark(x) if you have/have had any of the following conditions:

Cardiovascular disease	Angina	Arteriosclerosis	Heart attack
Congestive heart failure	Damaged heart valve	Mitral valve prolapsed	Heart murmur
Low blood pressure	High blood pressure	Pacemaker	
Other congenital heart defect (please describe)_____			
Rheumatic heart disease	Rheumatic fever	Abnormal bleeding	Anemia
Blood transfusion (if yes, date_____)			
Hemophilia	AIDS or HIV infection	Arthritis	Asthma
Autoimmune disease	Rheumatoid arthritis	Systemic lupus erythernatosus	Bronchitis
Emphysema	Sinus trouble	Tuberculosis	Chronic pain
Cancer	Chemotherapy	Radiation treatment	Diabetes Type I
Diabetes Type II	Chest pain upon exertion	Eating disorder	Malnutrition
Gastrointestinal disease	G.E. Reflux / heartburn	Ulcers	Thyroid problems
Stroke	Glaucoma	Hepatitis or jaundice	Liver disease
Epilepsy	Fainting spells or seizures	Sleep disorder	Kidney problems
Night sweats	Osteoporosis	Severe/rapid weight loss	Excessive urination
Mental health disorder (name_____)		Recurrent infections(name_____)	
Persistent swollen glands in neck		Severe headaches/migraines	
Neurological disorders (specify)_____			

Do you have any of the following:	Yes	No
Artificial (prosthetic heart valve)	___	___
Previous infective endocarditis	___	___
Damaged valves in transplanted heart	___	___
Congenital Heart Disease (CHD)	___	___
-Unrepaired, cyanotic CHD	___	___
-Repaired (completely) in last 6 mos	___	___
-Repaired CHD with residual defects	___	___

(Antibiotic prophylaxis is recommended for the conditions listed above to prevent infection)

Has a physician recommended that you take antibiotics prior to your dental treatment? ___YES ___NO
Name of physician making recommendation_____
Do you have any disease, condition, or problem not listed above that you think I should know about? ___YES ___ NO
Please explain_____

I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient/Legal Guardian Date

Doctor's Notes: