Dental History

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Primary reason for today's visit? ____________________________________

Date of last dental treatment? ____________ (M/D/Y)

Please check all statements that apply to you:

___I feel nervous about coming to the dentist ___I brush my teeth daily

___I floss my teeth daily ___I would describe my current dental health as good

___I think I may have tooth decay

Medical History

Family Doctor's name: _________________________PH#________________

When was your last medical checkup? ________________________

Have you ever had a serious illness or operation or have been hospitalized? Yes No If yes please explain ____

Are you being treated for any medical condition at the present or have you been treated within the past year? Yes No

Explain____

Have there been any changes in your general health in the past year? Yes No If yes please explain.

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Do you smoke? Yes No Do you chew tobacco? Yes No

For Women only: Are you pregnant? Yes No expected delivery date: ____________________

Are you breast feeding? Yes No Are you taking birth control pills? Yes No

Are you taking any medication, non-prescription drugs or herbal supplements of any kind?

Yes No if yes please list

____

Do you drink Grapefruit Juice? Yes No If yes how much per week? _______________

Cont. over……….

Do you have any allergies? Yes No Use the categories a) medications b) latex/rubber products

c) Other e.g. hay fever, food

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____

Have you ever had a peculiar or adverse reaction to any medications or injections? Yes No If yes please explain.

____

Do you have or have you ever had asthma? Yes No ________________________________

Do you have or have you ever had any heart or blood pressure problems? Yes No

____

Do you have or have you ever had a heart murmur, mitral valve prolapsed or rheumatic fever? Yes No

____

Do you have a prosthetic or artificial joint: Yes No ________________________________

Have you ever been advised by your doctor to take antibiotics before dental treatment?

Yes No ______________________

Do you have any conditions or therapies that could affect your immune system e.g. Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? Yes No If yes please explain

Have you ever had hepatitis, jaundice or liver disease? Yes No _______________________

Do you have a bleeding problem or bleeding disorder? Yes No ________________________

Do you have or have you ever had any of the following – please circle

AIDS Anemia Arthritis Asthma Cancer Chest Pain/Angina Congenital heart problems Diabetes Diet pill therapy Emphysema Epilepsy Fainting Glaucoma Drug/Alcohol dependency Hay fever Heart attack Hepatitis A Hepatitis B Hemophilia Herpes High blood pressure Hypoglycemia Kidney problems/disease Low blood pressure Lung disease Pacemaker Pain in jaw joints Parathyroid disease Prosthetic heart valve Psychiatric care Rheumatism Seizures Sickle cell anemia Sinus trouble Scarlet fever Shortness of breath Steroid therapy Stroke Thyroid disease Tuberculosis Ulcers Yellow jaundice

Please alert Dr. Orth to any medical conditions you may have/had not listed above

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To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: DATE:

____ ______________________