PATIENT INFORMATION AND HEALTH HISTORY

DATE _____
NAME_____BIRTHDATE _____
ADDRESS_____
TELEPHONE: (H)_____ (W):_____
CELL PHONE: _____E-MAIL: _____

PATIENT MEDICAL HISTORY

MEDICAL DOCTOR'S NAME _____
DATE OF LAST VISIT _____
LAST DENTIST'S NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with dentistry that you will be receiving. Thank you for answering the following questions.

High Point Dentistry

Have you ever had any of the following? No_____YES_____ (Please indicate)

____High blood pressure	____Heart murmur	____Hepatitis/Jaundice
____Rheumatic Fever	____Angina	____Stomach troubles
____Swollen ankles	____Stroke	____Tuberculosis
____Fainting/seizures	____ Anemia	____Glaucoma
____Low blood pressure	____Asthma	____Liver disease
____Epilepsy/convulsions	____Respiratory problems	____Aids or HIV infection
____Diabetes	____Emphysema	____Sexually transmitted disease
____Kidney diseases	____Cancer	____Other
____Thyroid problem	____Radiation therapy	
____Heart disease	____ Leukemia	
____Cardiac pacemaker	____Arthritis	
____Heart attack	____Joint replacement	

1. Are you under medical care at this time?	Yes	No	List_____
2. Have you ever been hospitalized for any surgical operation or serious illness?	Yes	No	List_____
3. Are you taking any medications including non-prescription drugs and or herbs?	Yes	No	List_____
4. Do you use tobacco?	Yes	No	How much per day_____
5. Do you use alcohol, cocaine or other drugs?	Yes	No	How Often ____How Much_____
6. Have you ever used prescription or nonprescription diet pills (Fen-Phen, Redux)?	Yes	No	
7. Do you snore or have been told you snore?	Yes	No	List_____
8. Have you been told you have sleep apnea or told you stop breathing when you sleep?	Yes	No	
9. Do you have allergies?	Yes	No	
10. Are you pregnant at this time?	Yes	No	

Updated _____ Patient Signature_____

DENTAL QUESTIONAIRE

1. Are you having a dental problem at this time?_____
2. When was your lest dental visit?_____
3. How often do you brush your teeth? _____Floss?_____
4. Do your gums bleed while brushing? Yes No
5. Do your gums bleed while flossing? Yes No
6. Are your teeth sensitive to hot, cold, sweet or sour foods. liquids?(circle) where_____
7. Have you noticed any loosening of your teeth? Yes No
8. Have you experienced any of the following problems with your jaw?
   a. Clicking? Yes No
   b. Pain (joint, ear, side of face)? Yes No
   c. Difficulty opening or closing? Yes No
   d. Difficulty in chewing? Yes No
9. Have you had any head, neck or jaw injuries? Yes No
10. Do you have frequent headaches? Yes No
11. Do you clench or grind your teeth awake or asleep? Yes No
12. Have you ever had:
    a. Implants Yes No
    b. Orthodontic treatment (braces)? Yes No
    c. Oral surgery? Yes No
    d. Gum treatment? Yes No
    e. Endodontics? (root canal therapy) Yes No
    f. Cosmetic dentistry? Yes No
13. Are you satisfied with the appearance or your teeth? Yes No
14. If you could improve your smile, what would you have done?_____
_____
15. Have you ever had an upsetting experience in the dental office? Yes No
16. Is there anything about having dental treatment that bothers you? Yes No
    If yes, please explain _____
17. Whom may we thank for referring you to our office? _____
18. What would you like to be called (nickname)?_____
19. Have you ever had local anesthetic (being numbed up) used in previous dental care? Yes No
20. Do you prefer it to be used? Yes No

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature_____ Date_____