

PATIENT NAME _____ DATE _____

DENTAL HISTORY

Previous Dentist's name _____ Phone # _____ Date of last dental visit _____
Date of last x-rays _____ Treatment completed at last dental visit _____
Is there anything about your dentistry or your dental health that you'd like us to be aware of? _____
If you could change your smile, what would you change? _____
How long do you want to keep your remaining teeth? _____

TMJ SCREENING

Have you ever had a problem with your jaw joints (your TMJ's)? Y N
Have you ever been injured by a blow to the jaw? Y N
Do your jaw joints ever hurt or become tender when you chew or talk? Y N
Do you notice any tenderness when you open wide? Y N
Does your jaw ever have any clicks, pops, or grating sounds? Y N
Do you have frequent headaches? Y N If so, how often, where? _____
Has your jaw ever locked open? Y N Locked closed? Y N Do you ever have difficulty opening? Y N
Have you ever been treated for a TMJ problem? **BITE SPLINT MEDICATION SURGERY ORTHODONTICS**
PHYSICAL THERAPY EQUILIBRATION COUNSELING

MEDICAL HISTORY

Physician's Name _____ Phone # _____
Have you ever been hospitalized or had a major operation? Y N Explain _____
Are you taking any medications, pills, or drugs? Please list names / dosages _____

Do you have any allergies to: **ASPIRIN PENICILLIN CODEINE ACRYLIC METAL LATEX RUBBER SULFA OTHER**
Do you smoke or chew tobacco? Y N Amount per day _____ Do you need antibiotic prior to dental work? Y N
WOMEN (please circle) **PREGNANT / TRYING TO GET PREGNANT NURSING TAKING ORAL CONTRACEPTIVES**

Do you now have or have you ever had any of the following:

| | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Allergies/Hives | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Reflux/Indigestion |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cough | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Intestinal Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> GERD | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Other _____ |

Have you had any serious illness/medical condition not listed above? Y N _____

Do you wish to talk privately to Dr. Brown or Dr. Amos about any concern/problem? Y N _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at my next appointment.

(Signature) Date _____

Reviewed by Doctor _____ Date _____