TERHUNE DENTAL

NAME ________________________

YOUR DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc) ______________________________

Previous Dentist ____________________ Last Visit __________ Date of last cleaning _________

Reason for changing dentists____

What problems have you had with past dental treatment? ______________________________

Are you nervous about seeing a dentist? Y N If yes, please explain:______________________

How often do you brush? _________________ Do you floss? Y N If yes, how often? ______________

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N My gums feel tender or swollen.
Y N I avoid brushing part of my mouth due to pain.
Y N I have problems eating.
Y N I like my smile.
Y N I have had orthodontics.
Y N I want my teeth straighter.
Y N I want my teeth whiter.
Y N I have had a facial or jaw injury.

What are your dental priorities? ____

YOUR MEDICAL HISTORY

I consider my health to be (please circle one): Excellent Good Fair Poor

Do you have or have you had any of the following?

Y N Heart Disease
Y N Heart Murmur/Mitral Valve Prolapse
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Abnormal Blood Pressure
Y N Anemia
Y N Prolonged Bleeding Disorder
Y N Tuberculosis or Lung Disease
Y N Asthma
Y N Hay Fever
Y N Sinus Trouble
Y N Epilepsy/Seizures
Y N Ulcers
Y N Implants/Artificial Joints: Hip Knee Other
Y N I use tobacco. If yes, how much per day? ___ How many years? ___
Y N I have consumed alcohol within the last 24 hours.
Y N I usually take an antibiotic prior to dental treatment.
Y N Have you ever taken Fen-Phen or Redux?
Y N Liver Disease
Y N Jaundice
Y N Hepatitis Type ___
Y N Diabetes
Y N Excessive Urination and/or Thirst
Y N Infectious Mononucleosis (Mono)
Y N Herpes
Y N Arthritis
Y N Sexually Transmitted Disease/AIDS
Y N Kidney Disease
Y N Tumor or Malignancy
Y N Cancer/Chemotherapy
Y N Radiation Treatment
Y N History of Drug Addiction
Y N Immune Suppressed Disorder
Y N Hearing Loss
Y N Fainting Spells
Y N Glaucoma
Y N History of Emotional or Nervous Disorders

Y N I have had major surgery: Year ______ Type of operation _____________ Year ______ Type of operation _____________

Y N Any other medical problem or medical history not listed on this form? ______________________

WOMEN ONLY: Y N Are you taking birth control medicine? Y N Are you or could you be pregnant or nursing?

Are you allergic to any of the following?

Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Penicillin
Y N Codeine
Y N Latex, Metals, Plastics
Y N Local Anesthetics (Novocaine)
Y N Other Medications ___________________

Please list all medications you are currently taking:

Medicine ___________________ Condition _________________
Medicine ___________________ Condition _________________
Medicine ___________________ Condition _________________
Medicine ___________________ Condition _________________
Medicine ___________________ Condition _________________
Medicine ___________________ Condition _________________
Physician's Name_____________ Phone___ _________________
Address _____________________ Fax _____________________

In the event of an emergency, please contact:

Name______________________________ Relationship _________________ Phone ____________________
Name______________________________ Relationship _________________ Phone ____________________
Patient or Parent/Guardian Signature __________________________________ Date ____________________
Initial Review (Dr. Signature/Date) ______________________ Periodic Review (Dr. Signature/Date) ______________________